

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

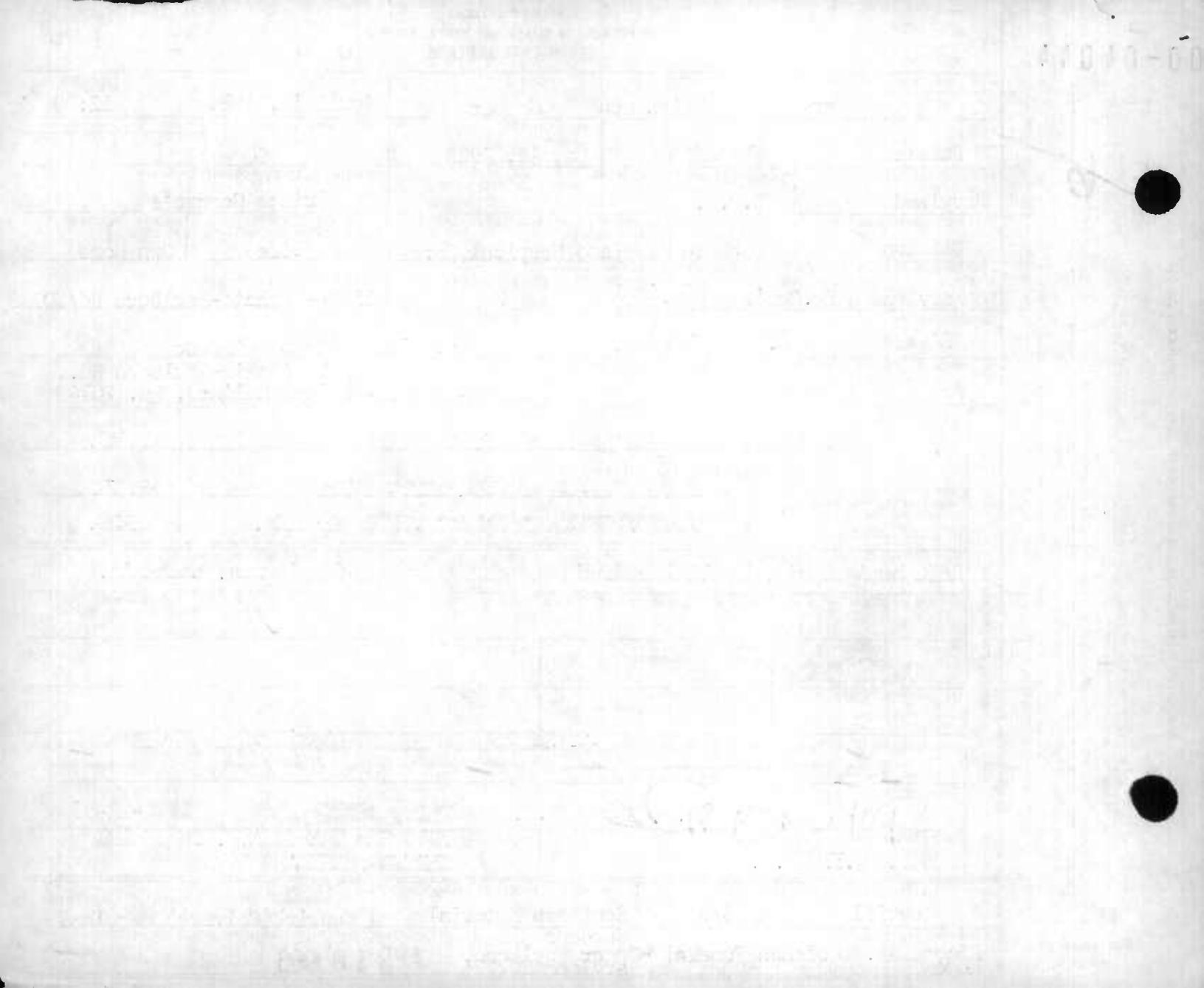
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in full, it should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 7 days after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical certifying physician should be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH																					
8 0 1 2 2 1 6											REG. NO.										
1 - FOR STATE REGISTRAR			I. DECEASED NAME			FIRST MIDDLE LAST			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR									
Mary			Elizabeth			Garner			April 12, 1986			12:00 P.M.									
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE IN YEARS (LAST BIRTHDAY)			IF UNDER 1 YEAR			IF UNDER 24 HRS								
Female		White		MONTH DAY YEAR			60 YRS			MONTHS DAYS			HOURS MIN.								
7a. BIRTHPLACE STATE OR FOREIGN COUNTRY		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY		
Maryland		U.S.A.		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			Prince George's			Clinton			Southern Maryland Hospital Cntr			Housewife			Own Home		
13a. STATE		13b. COUNTY		13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE			14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME					
Maryland		Pr. Geo's		Capitol Heights			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			1502--Ritchie-Marlboro Rd/20743			Edgar			Mary Irene Stamp Windsor					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIOPULMONARY ARREST			ADDRESS			16c. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH								
NO		-----								1502 Ritchie-Marlboro Rd., Joseph Garner-Capitol Heights, Md. 20743						HOURS.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIOPULMONARY ARREST			DOUE TO, OR AS A CONSEQUENCE OF (b) TERMINAL LUNG CANCER, METASTASIZED			DOUE TO, OR AS A CONSEQUENCE OF (c) CHRONIC OBSTRUCTIVE PULMONARY DISEASE.									MONTHS.						
																		YEARS.			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. Left hemiparesis, brain metastasized, with episode of seizures. cachexia.																					
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?												
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>												
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)															
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE															
22a. I certify that (I) (this hospital) attended the deceased from Jan. 22 1986, 19, to April 12, 1986, that (I) (we) last saw the deceased alive on APRIL 12, 1986, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																					
22b. SIGNATURE <i>Peter W. Yim</i>			DEGREE M.D.			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 4-12-86												
22d. PHYSICIAN'S NAME (TYPE OR PRINT) PETER W. YIM M.D.			22e. ADDRESS 7900 OLD BRANCH AVE. SUITE 101 CLINTON, MARYLAND 20735																		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 4/16/86			23c. NAME OF CEMETERY OR CREMATORIAL Gardens			23d. LOCATION CITY OR TOWN Dunkirk (Calvert), Maryland			23e. COUNTY STATE									
24. FUNERAL DIRECTOR Richard A. Coleman Funeral Home			24a. DATE REC'D. BY REGISTRAR APR 18 1986			24b. REGISTRAR'S SIGNATURE <i>Julia Davidson Anderson</i>															

11040-60



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL, IN ITEM 1B, GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 4 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PLESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO. 12217	
1- STATE REGISTRAR			2a. DATE KNOWN OF EST- DEATH MATED <input type="checkbox"/> 4-20 1986									2b. HOUR M	
1. DECEASED NAME (TYPE OR PRINT) Ireland L. Garrett			2c. DATE PRONOUNCED DEAD 4-20 1986			2d. HOUR 12:30 P.M.							
3. SEX Male		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR April 27 1913		6. AGE (IN YEARS) LAST BIRTHDAY 73 YRS.		7. IF UNDER 1 YR. MONTHS DAYS		8. IF UNDER 24 HRS. HOURS MIN			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Texas		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		WIDOWED <input type="checkbox"/>		DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's			
10. CITY OR TOWN OF DEATH Andrews A.F. Base			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Andrews AFB Hospital						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Engineer			12b. KIND OF BUSINESS OR INDUSTRY US Government	
13a. STATE Maryland		13b. COUNTY Howard		13c. CITY OR TOWN Columbia		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 10112 Spring Pools Lane			21044		
14. FATHER'S NAME Anderson			15. MOTHER'S MAIDEN NAME Cora										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) yes			16b. SOCIAL SECURITY NO. 225-52-7689						17. INFORMANT Bice Garrett/wife/Lane Columbia, Maryland			ADDRESS 10112 Spring Pool	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Prophetic arteriovenous claudication vascular disease</i>												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) _____ (c) _____													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?									20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY STATE		
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>													
ACTUAL SIGNATURE <i>Augusto P. Rodriguez</i>		TITLE (SPECIFY) M.D. Deputy										DATE SIGNED 4-22-86	
EXAMINER'S NAME (TYPE OR PRINT) Augusto P. Rodriguez, M.D.			ADDRESS 5009 Rayburn Ct, Temple Hills, Md										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 4/25/86			23c. NAME OF CEMETERY OR CREMATORIAL Arlington National			23d. LOCATION CITY OR TOWN Arlington			COUNTY Virginia STATE	
24. FUNERAL DIRECTOR NAME McGuire Funeral Service			ADDRESS 7400 Georgia Ave Wash.			D.C.			25a. DATE REC'D. BY REGISTRAR APR 28 1986			25b. REGISTRAR'S SIGNATURE <i>John Davidson - Rodriguez</i>	

83070-00



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon copy of page 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 18 is marked or Item 19 shows any injury, or other traumatic event, the medical examiner should be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 2218				
1. DECEASED NAME (TYPE OR PRINT)		FIRST PAULINE	MIDDLE	LAST GEORGE	2a. DATE OF DEATH MONTH April 28, 1986	DAY	YEAR	2b. HOUR 11A M
3. SEX FEMALE		RACE BLACK	5. DATE OF BIRTH MONTH DAY YEAR July 12, 1917		6. AGE (IN YEARS LAST BIRTHDAY) 68 YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? UNITED STATES		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGE MD.		
10. CITY OR TOWN OF DEATH ACCOKEEK		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 18401 Livingston Road		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) DOMESTIC			12b. KIND OF BUSINESS OR INDUSTRY PRIVATE	
13a. STATE MARYLAND		13b. COUNTY P.G.	13c. CITY OR TOWN ACCOKEEK	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 18401 Livingston Rd./ 20607		
14. FATHER'S NAME FIRST FRANK		MIDDLE	LAST RAYMOND	15. MOTHER'S MAIDEN NAME FIRST EDMONIA		MIDDLE	LAST DYSON	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 578-28-5412		17. INFORMANT Marian A. Butler		ADDRESS 12507 Livingston Rd. Fort Wash., Md.		
18. CAUSE OF DEATH (Enter only one cause per line for 10, 1b), and c. PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiopulmonary arrest APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 70 min								
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause, lost								
DUE TO, OR AS A CONSEQUENCE OF (b) Congestive heart failure 3 days								
DUE TO, OR AS A CONSEQUENCE OF (c) pulmonary edema 3 days								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1b Cancer of prostate with metastasis, Diabetes mellitus, Ketonosis								
19a. DATE OF OPERATION 6/9/82		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Left A Karupation occasion			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b PART 1 OR PART 2) A				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/> A		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) 10th		21f. LOCATION STREET N/A CITY OR TOWN CITY COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from 3/13/81 to 4/20/86, that (I) (we) lost the deceased alive on 3/24/86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE Paul Pritchett MD		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> MEDICAL STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 4/28/86		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Paul Pritchett		22e. ADDRESS LaPlata, Maryland						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE May 2, '86		23c. NAME OF CEMETERY OR CREMATORIAL Metropolitan U.M.		23d. LOCATION CITY OR TOWN Pomonkey		23e. COUNTY Charles Md. STATE
24. FUNERAL DIRECTOR NAME THORNTON FUNERAL HOME		ADDRESS POMONKEY, MD		25a. DATE REC'D. BY REGISTRAR MAY 01 1986		25b. REGISTRAR'S SIGNATURE John Davidson Pendleton		
DHMH - 16 60M 7/84 (VRA 15, 4)								

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TO HOSPITAL OR ATTENDING PHYSICIAN. The Hospital or attending physician may direct the removal of the patient to another hospital or physician.

HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after the deceased may be removed by the hospital or attending physician.

MEDICAL CERTIFICATION

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 12219

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR				
Richard M. GILLAM						04	19	86	4:28p _m					
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR				
Male		White		MONTH	DAY	YEAR	78	YRS.			IF UNDER 24 HRS			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8			9. BALTIMORE CITY OR COUNTY OF DEATH							
Vermont		U.S.A.		MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			Prince George's County,			MD.				
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY							
Riverdale		Leland Memorial Hospital		weapons inspector			U.S. Navy							
13. RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)														
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?			13e. STREET ADDRESS / ZIP CODE			Md.		
Maryland		Prince Georges		Hyattsville		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			4907-40th Place Hyattsville, 20781					
14. FATHER'S NAME FIRST		MIDDLE	LAST	15. MOTHER'S MAIDEN NAME			16. SOCIAL SECURITY NO.			17. INFORMANT				
Herbert		L.	Gillam	Elizabeth			578-38-2266			Jean D. Fry			4907-40th Place	
18a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES OR NO UNKNOWN)		18b. (IF YES, GIVE WAR OR DATES)		18c. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH										
Yes		1927-1930												
19. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiorespiratory arrest</u>														
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Aspiration pneumonia</u>														
DUE TO, OR AS A CONSEQUENCE OF (c) <u></u>														
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)														
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?						
					YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)									
		P.M. 19												
21d. INJURY OCCURRED <small>AT HOME <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/></small>		21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY	STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>4/2</u> , 19 <u>86</u> , to <u>4/19</u> , 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>4/19</u> , 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.														
22b. SIGNATURE		DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED						
<u>Pimolvarn Limpuangthip MD</u>														
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS												
PIMOLVARN LIMPUNGTHIP, M.D.		6201 Riverdale Rd #102 Riverdale, Md 20737												
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION CITY OR TOWN		23e. COUNTY			STATE		
Burial		4-22-86		Cedar Hill Cemetery			Suitland		Prince Georges			Md.		
24. FUNERAL DIRECTOR NAME		ADDRESS			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE						
W.W. Chambers, Co.		Riverdale, Md.			APR 22 1986			John Davidson-Randall						

2188 COOLIDGE, LITTLETON

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon copy of page 2 and file within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 22 shows any injury, or other traumatic event, the medical examiner should be notified at once.

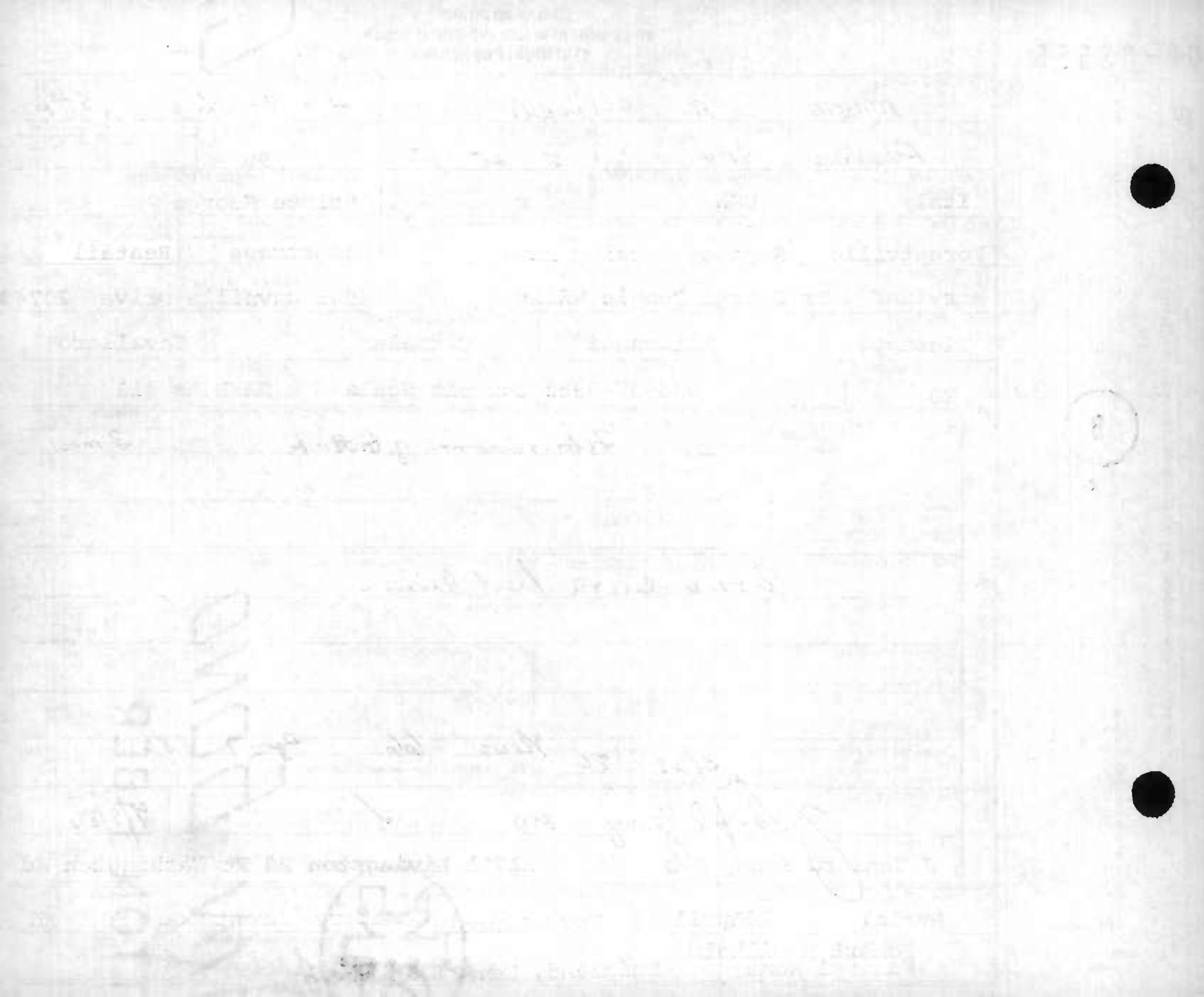
MEDICAL CERTIFICATION

1 - FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 8612220

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR	
			MARIA	A.	Givoni	4-7-86				5:50 PM	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		
Female		Cau		MONTH	DAY	YEAR	MONTHS	DAYS	IF UNDER 24 HRS		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8		MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH		
Italy		USA							Prince George		
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY					
Forestville		Regency Nursing Home		Seamstress		Retail					
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS / ZIP CODE			
Maryland		Pr George		Temple Hills		S <input type="checkbox"/> NO <input type="checkbox"/>		4005 Davnille Drive 20748			
14. FATHER'S NAME FIRST		MIDDLE		LAST		15. MOTHER'S MAIDEN NAME FIRST		MIDDLE			
Giuseppe				Alibrandi		Carmela		Cavallaro			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT		ADDRESS					
NO		083-07-9382		Carmela Scala		SAME As #13					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) _____						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 mos.					
DUE TO, OR AS A CONSEQUENCE OF (b) _____											
DUE TO, OR AS A CONSEQUENCE OF (c) _____											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a). <i>Arterioscler. & heart disease</i>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?					
				YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <i>3/28 1986</i> , to <i>Nov. 19, 1986</i> , that (I) (we) last saw the deceased alive on <i>3/28 1986</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <i>J. Sanford Young MD</i>		DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <i>7/8/86</i>					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>J. Sanford Young MD</i>		22e. ADDRESS 11701 Livingston Rd Ft Washington Md									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 10 April 86		23c. NAME OF CEMETERY OR CREMATORIAL Fort Lincoln Cemetery		23d. LOCATION CITY OR TOWN Brentwood COUNTY PG STATE Md					
24. FUNERAL DIRECTOR NAME Robert E Wilhelm Funeral Home		ADDRESS Suitland, Md.		25a. DATE REC'D. BY REGISTRAR APR 14 1986		25b. REGISTRAR'S SIGNATURE <i>John J. Kilkenny</i>					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be referred by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO. 8012221
1 - STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT) LEE Gladys D. Lee GLADYS						2a. DATE OF DEATH 4-19-86		2b. HOUR 635 AM		
3. SEX Female		4. RACE Caucasian		5. DATE OF BIRTH MONTH December DAY 8 YEAR 1900		6. AGE (IN YEARS LAST BIRTHDAY) 85 YRS		7a. IF UNDER 1 YEAR MONTHS 0 DAYS 0		7b. IF UNDER 24 HRS HOURS 0 MIN. 0		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's MD.						
10. CITY OR TOWN OF DEATH Clinton		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Southern Maryland Hospital						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY Home		
13a. STATE Maryland		13b. COUNTY P.G.		13c. CITY OR TOWN Clinton		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 9500 Michael Drive 20735				
14. FATHER'S NAME Wilbur		C. MIDDLE VanHorn		15. MOTHER'S MAIDEN NAME Annie								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. N/A 577-52-0376		17. INFORMANT Adelbert W. Lee		ADDRESS Same as 13 A-E						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebrovascular accident APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH												
DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerotic Cerebrovascular Disease												
DUE TO, OR AS A CONSEQUENCE OF (c) Convulsive Disorder												
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I. Diabetes Mellitus, Hypothyroidism												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. 19 P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) YEAR 1986								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE		
22a. I certify that (I) (this hospital) attended the deceased from 4-18-86 to 4-19-86 , that (we) last saw the deceased alive on 4-18-86 , and that in (my) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (not) view the body after death.												
22b. SIGNATURE R. A. McConaughy MD		22c. DEGREE				ATTENDING PHYSICIAN <input type="checkbox"/>		MEDICAL DIRECTOR <input type="checkbox"/>		STAFF PHYSICIAN <input checked="" type="checkbox"/>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) R. A. McConaughy		22e. ADDRESS 5618 St. Barnabus Rd. Oxon Hill Md. 20745				22f. DATE SIGNED 4-19-86						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 4/19/86		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		23d. LOCATION CITY OR TOWN Suitland		CITY OR TOWN COUNTY P.G.		STATE Maryland		
24. FUNERAL DIRECTOR NAME Lee Funeral Home, Inc.		ADDRESS 6633 Old Alexander Ferry Rd. Clinton, Md. 20735		25a. DATE REC'D. BY REGISTRAR APR 25 1986		25b. REGISTRAR'S SIGNATURE Jane [Signature]						

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Form 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Form 2 should be detached from it at the burial/troupe permit. Then please remove 2 blue papers. Form 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene and prior to burial/cremation or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other than normal event, the medical examiner should be consulted.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO. 12222	
1. DECEASED NAME <small>(TYPE OR PRINT)</small>				FIRST HUGO	MIDDLE J.	LAST GOETZ	2a. DATE OF DEATH MONTH DAY YEAR				2b. HOUR 4/16/86 2:04 p.m.		
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 6 10 1900			6. AGE (IN YEARS LAST BIRTHDAY) 85		IF UNDER 1 YEAR MONTHS DAYS				
7a. BIRTHPLACE <small>(NAME OF FOREIGN COUNTRY)</small> Washington, D.C.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGE'S COUNTY			MD.			
10. CITY OR TOWN OF DEATH CLINTON		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION <small>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)</small> SOUTHERN MARYLAND HOSPITAL CENTER		12a. USUAL OCCUPATION <small>(TYPE OF WORK FOR MOST OF WORKING LIFE)</small> Machinist			12b. KIND OF BUSINESS OR INDUSTRY Fed. Gov't.						
13. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13a. STATE Md.		13b. COUNTY Anne Arundel		13c. CITY OR TOWN Lethian		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 87 Edward Ln. 20711			
14. FATHER'S NAME FIRST Joseph		MIDDLE 	LAST Goetz	15. MOTHER'S MAIDEN NAME FIRST Unknown			MIDDLE 	LAST 	ADDRESS				
16. WAS DECEASED EVER IN U.S. ARMED FORCES? <small>(YES, NO OR UNKNOWN)</small> No		16b. SOCIAL SECURITY NO. 579-38-0008T		17. INFORMANT Dorothy L. McLean			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) a acute cardiopulmonary arrest			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last		{ (b) arteriovenous heart disease			{ (c) 								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I. Kidney failure, congestive heart failure													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH <small>(IF EITHER, NOTIFY MEDICAL EXAMINER)</small>		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN	COUNTY	STATE			
22a. I certify that (I) (this hospital) attended the deceased from 3/29 , 19 86 , to 4/16 , 19 86 , that (I) (we) last saw the deceased alive on 4/16 , 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												22c. DATE SIGNED April 16, 1986	
22b. SIGNATURE Helen Capone		22c. DEGREE MD			ATTENDING PHYSICIAN <input checked="" type="checkbox"/>	MEDICAL DIRECTOR <input type="checkbox"/>	STAFF PHYSICIAN <input type="checkbox"/>						
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Helen D. CAPONE MD		22e. ADDRESS 7501 Surratt Rd Clinton Md 20731											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 4-18-86		23c. NAME OF CEMETERY OR CREMATORIAL Lakemont Mem. Gardens			23d. LOCATION CITY OR TOWN Davidsonville		COUNTY A.A.	STATE Md.			
24. FUNERAL DIRECTOR NAME G.P. KALAS		ADDRESS 6160 OXON HILL RD. OXON HILL MD.			25a. DATE REC'D. BY REGISTRAR APR 21 1986			25b. REGISTRAR'S SIGNATURE Jeha Dawson					
DHMH - 16 60M 7/84 (VRA 15, 4)													

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

physician and completely filled in by the attending physician. Pages 1 and 2 should be filed within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be detached for use at the burial/transit permit. Then please remember to bury or cremate prior to removal, with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked shows any injury, or other traumatic event, the medical examiner must be notified of same.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												
B 6 2 2 2 5 REG. NO.												
1 - STATE REGISTRAR			1 DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a DATE OF DEATH MONTH DAY YEAR			
Theresa R. Golden						04-07-86			2b HOUR 0830 AM			
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
Female		White		12 09 1899			87					
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH			MD.	
Florida		USA						Prince Georges County				
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b KIND OF BUSINESS OR INDUSTRY				
Riverdale		Leland Memorial Hospital			Housewife			Own Home				
13a STATE MD		13b COUNTY PG		13c CITY OR TOWN Hyattsville		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS / ZIP CODE 6500 Riggs Rd		20783		
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST										
Arao Idr		Rosa Cohen										
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b SOCIAL SECURITY NO.			17 INFORMANT			ADDRESS				
No		579-48-7078			Violag May			3425 Eads St, NE Wash, DC				
18 CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardio pulmonary arrest</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH												
912 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Pneumonia</u> (c) <u>Lepis, Seizure</u> (c) <u>Aspiration</u>												
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)												
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED					20a AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET			CITY OR TOWN		COUNTY	STATE		
22a. I certify that (I) (this hospital) attended the deceased from <u>4-5-86</u> to <u>4-7-86</u> , that (I) (we) last saw the deceased alive on <u>4-6-86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE <u>Revathy Murthy</u>		22c DEGREE <u>MBS</u>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22d. DATE SIGNED <u>4/7/86</u>						
22e. PHYSICIAN'S NAME (TYPE OR PRINT) <u>REVATHY MURTHY</u>		22f. ADDRESS <u>6130 LANDOVER Rd, LANDOVER, MD</u>										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE <u>4-10-86</u>		23c. NAME OF CEMETERY OR CREMATORIAL <u>Arlington North Park</u>			23d. LOCATION CITY OR TOWN <u>Arlington, Arlington, VA</u>			23e. COUNTY <u>VA</u>		
24. FUNERAL DIRECTOR NAME <u>N.W. Chambers Co.</u>		25a. DATE REC'D. BY REGISTRAR <u>APR 14 1986</u>		25b. REGISTRAR'S SIGNATURE <u>J. L. Baird - Pender</u>								
ADDRESS <u>517-11th St, SE Wash, DC</u>												

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

relinquished by the Hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked as "No" to any injury, or other traumatic event, the medical examiner must be notified.

1 - STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 b REG. NO. 1 2 2 2 4

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR				
Robert P. Gooding						April 30, 1986				12:40 Pm				
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY) IF UNDER 1 YEAR MONTHS DAYS								
MALE		WHITE		SEPT. 23, 1921		64 YRS IF UNDER 24 HRS MONTHS DAYS HOURS MIN.								
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Prince George's MD.								
MASS.		U.S.A.												
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY								
BELTSVILLE		Greater Laurel Beltsville Hospital		RET. COMM. SPEC.		U.S. GOVT.								
13a. STATE Md.						13b. COUNTY P.G.C.		13c. CITY OR TOWN BELTSVILLE		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE 4806 OLYMPIA AVE. 20705	
14. FATHER'S NAME FIRST MIDDLE LAST						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST								
HOMER B. GOODING		LOLA E. POWERS												
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS								
YES WWII		114-22-8619		LEONORE M. GOODING		(SAME AS ITEM #13)								
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH								
cardiac arrest						2 min.								
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) atherosclerotic heart disease						2 yrs.								
DUE TO, OR AS A CONSEQUENCE OF (c) diabetes mellitus						7 yrs.								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a.														
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?						
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)										
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE				
22a. I certify that (1) (this hospital) attended the deceased from July 19, 85, to April 19, 86, that (1) (we) last saw the deceased alive on April 26, 19, 86, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) (did) (did not) view the body after death.														
22b. SIGNATURE <i>Susan Leibenthal</i>		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/>		MEDICAL DIRECTOR <input type="checkbox"/>		STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 5/1/86			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Susan Leibenthal, M.D.		22e. ADDRESS 6525 Belcrest Rd, Hyattsville, Md. 20782												
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION		23b. DATE 5-1-1986		23c. NAME OF CEMETERY OR CREMATORIAL CHAMBERS CREMATORY		23d. LOCATION CITY OR TOWN RIVERDALE, Md.		COUNTY		STATE				
24. FUNERAL DIRECTOR NAME W. W. CHAMBERS CO.		ADDRESS RIVERDALE, Md. 20737		25a. DATE REC'D. BY REGISTRAR MAY 6 1986		25b. REGISTRAR'S SIGNATURE								

(800) 343-2222

00-05323

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM. 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 4 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 2026

1. DECEASED NAME (TYPE OR PRINT)			FIRST Willie	MIDDLE Jo	LAST Gossett	2a. DATE KNOWN OF ESTI- DEATH MATED	MONTH MAY	DAY 25	YEAR 1986	HOUR 20		
1. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH Sept.	DAY 28, 1922	YEAR 63	6. AGE (IN YEARS LAST BIRTHDAY) 63 yrs.	IF UNDER 1 YR. MONTHS 0	IF UNDER 24 HRS. DAYS 0	HOURS 0	MIN 0	2d HOUR M		
7a. BIRTHPLACE - STATE OR FOREIGN COUNTRY Georgia		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED		2c. DATE PRONOUNCED DEAD April 25, 1986					2d HOUR 4:15	
11. CITY OR TOWN OF DEATH Cheverly		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) P.G. Nursing Care Center					12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Supervisor					12b. KIND OF BUSINESS OR INDUSTRY Drug Co.
13a. STATE Maryland	13b. COUNTY P.G.	13c. CITY OR TOWN Hyattsville	13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		13e. STREET ADDRESS 5406 Hamilton Street #2 20781							
14. FATHER'S NAME FIRST Joseph		MIDDLE W.	LAST Bray	15. MOTHER'S MAIDEN NAME FIRST Lucy								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 239-20-5706		17. INFORMANT Mary L. Whitman		ADDRESS New London, N.C. 28127						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of the breast, metastatic DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a). Severe degenerative multi-focal osteoporosis, with Left Humeral Fracture												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?					20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 4 P.M. 4-19 1986		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) ? Pathologic fracture								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) Hospital, P.G.C.H.		21f. LOCATION STREET 11		CITY OR TOWN Cheverly, Prince George's, Md.						
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion												
ACTUAL SIGNATURE <i>Augusto P. Rodriguez</i>		TITLE (SPECIFY) M.D.					MEDICAL EXAMINER Augusto P. Rodriguez					
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS 5009 Rayburn Ct. Camp Spgs, Md. 20748					DATE SIGNED Apr. 28, 1986					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Apr. 30, 1986		23c. NAME OF CEMETERY OR CREMATORIAL Fort Lincoln Cemetery		23d. LOCATION CITY OR TOWN Brentwood		COUNTY P.G.			STATE Maryland	
24. FUNERAL DIRECTOR NAME F. Gasch's Sons F.H. P.A.		ADDRESS Hyattsville, Md.		25a. DATE REC'D. BY REGISTRAR MAY 1 1986		25b. REGISTRAR'S SIGNATURE <i>L. Kavinder Pendell</i>						
DHMH - 17 (VR A15 ME (5)) 20M 4/82												

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For the first time in history, the world has been brought together by a common language.

260 of 300

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM. 3; RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARSHALL 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12226

REG. NO.

1-
FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE KNOWN OF ESTI- MATED DEATH	MONTH	DAY	YEAR	2b. HOUR	
			R.C.	O.	Graves	3/16/1986					
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	7. IF UNDER 1 YR. MONTHS DAYS	8. IF UNDER 24 HRS. HOURS MIN	2c. DATE PRONOUNCED DEAD	MONTH	DAY	YEAR	2d. HOUR	
M	B	Dec 9 38	47 yrs.			4/14/1986				3:55 P.M.	
7a. BIRTHPLACE STATE OR FOREIGN COUNTRY		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED		9. BALTIMORE CITY OR COUNTY OF DEATH					
Va		U.S.A				Prince George's County, MD					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
Cheverly		Beaver Dam Creek				Soldiers Home		domestic			
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS			
Md.		PG.				YES <input checked="" type="checkbox"/>		5205 Newton St. 20784			
14. FATHER'S NAME FIRST		MIDDLE	LAST		15. MOTHER'S MAIDEN NAME FIRST		MIDDLE			LAST	
Roy			Graves		Vinnie					Clark	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS					
NO		225-46-1907		Vinnie		Graves RT 4 Chatham Va					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Drowning											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c) DUE TO, OR AS A CONSEQUENCE OF											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:											
Seizure Disorder		19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?					
						YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR ? P.M. 4/14/1986		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) subject drowned							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) creek		21f. LOCATION STREET Beaver Dam Creek, Cheverly, Pr. Geo., Md.		CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held an death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion									
ACTUAL SIGNATURE Margarita Korell		TITLE (SPECIFY) M.D. Assistant		MEDICAL EXAMINER							
EXAMINER'S NAME (TYPE OR PRINT)		Margarita A. Korell, M.D.		ADDRESS		111 Penn St.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 4-19-86		23c. NAME OF CEMETERY OR CREMATORIAL Union Hall Church Cem		23d. LOCATION CITY OR TOWN Chatham					
24. FUNERAL DIRECTOR NAME Carlton C. Douglass		ADDRESS 1348 N. Calhoun St.		25a. DATE REC'D. BY REGISTRAR APR 18 1986		25b. REGISTRAR'S SIGNATURE John Davidson-Korell					

50-10-10

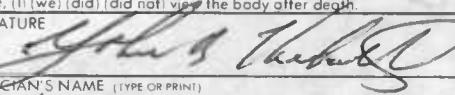
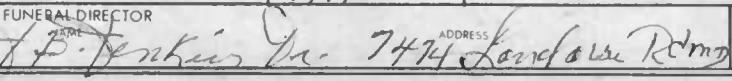
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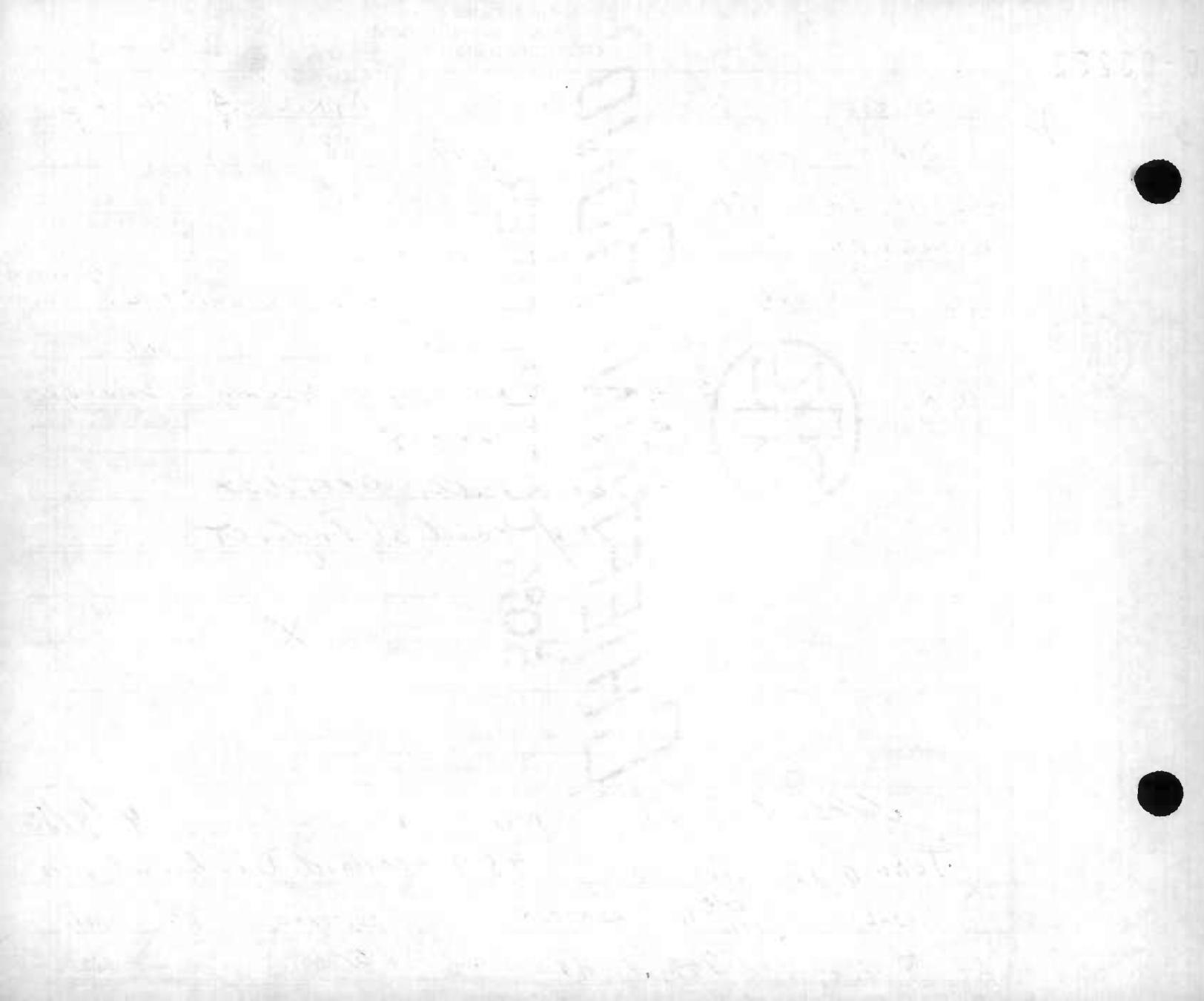
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be detached for use as the burial/transit permit. Then please remove carbon papers. with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 18 shows any injury, or other traumatic event, the medical examiner will be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO. 12221	
1. FOR STATE REGISTRAR			2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR				
1/ DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	APRIL	4	1986	6 ⁰⁰	P.M.			
3. SEX			4. RACE	5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR MONTHS DAYS			
FEMALE			BLACK	MONTH	DAY	YEAR	88			IF UNDER 24 HRS MONTHS HOURS MIN.			
7a. BIRTHPLACE (COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH PG				
GREENBELT MD			USA										
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY				
GREENBELT MD			GREENBELT NURSING CENTER										
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)													
13b. STATE MD			13b. COUNTY CAP. HGTB			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>				
									13e. STREET ADDRESS / ZIP CODE 521 - EASTERN AVE. MD.				
14. FATHER'S NAME FIRST LOUIS			MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST MARY			MIDDLE	LAST UNK				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) UNK			17. INFORMANT			ADDRESS				
			228460241			CARRIE SMITH, 1917 MENH. AVE, SE. WASHINGTON, D.C.							
18. CAUSE OF DEATH (Enter only one cause per line for item 18b, and c.) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Cardiovascular accident</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first.												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
(c) <u>Myocardial Infarct</u>													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN	COUNTY	STATE		
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE 			DEGREE MD			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 4/9/86				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) John B. Theobald			22e. ADDRESS 9811 Maryland Dr. Laurel MD										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE 4/9/86			23c. NAME OF CEMETERY OR CREMATORIAL LINCOLN			23d. LOCATION CITY OR TOWN SUITLAND				
24. FUNERAL DIRECTOR 			ADDRESS 744 Landover Rd. mg			25a. DATE REC'D. BY REGISTRAR APR 10 1986			25b. REGISTRAR'S SIGNATURE John Davidson-Randall				



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be witnessed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use at the burial/Hospital permit. Then please enclose car both papers, #page 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked off, item 18 below may apply, an other traumatic event. If medical conditions can be noted, check one.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 12228			
1 - FOR STATE REGISTRAR			DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST		2a DATE OF DEATH MONTH DAY YEAR			2b. HOUR		
			Louis J. GRAYSON					Apr. 16 30 1986			2 p.m.		
3. SEX			4 RACE			5. DATE OF BIRTH MONTH DAY YEAR			6 AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
Male			caucasian			July 16 1897			88 YRS				
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b CITIZEN OF WHAT COUNTRY?			8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH				
Hartford, Conn.			USA						Prince George's MD.				
10 CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY				
Laurel			Home Care Nursing Care			Ins. Broker			Insurance			20816	
13a STATE Md.			13c CITY OR TOWN Mont. Bethesda			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS 4956 Sentinel Dr. #106				
14 FATHER'S NAME FIRST MIDDLE LAST			15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST										
unknow			unknow										
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no			16b SOCIAL SECURITY NO. -----			17. INFORMANT Aline Grayson same as 13e			ADDRESS				
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost			b) <u>congestive heart failure</u>										
			c) <u>coronary artery disease</u>										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)													
Pneumonia													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
19			19			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET _____ CITY OR TOWN _____ COUNTY _____ STATE _____							
22a. I certify that (I) (this hospital) attended the deceased from <u>Oct 20</u> , 19 <u>82</u> , to <u>present</u> , 19 <u>86</u> , that (I) (we) last saw the deceased alive on <u>Apr 16</u> , 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE <i>Joel Mulhausen MD</i>			DEGREE						22c. DATE SIGNED <u>4/30/86</u>				
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS 4550 Montgomery Ave., Suite 915 North Bethesda, Maryland 20814										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation			23b. DATE 5/1/86			23c. NAME OF CEMETERY OR CREMATORIAL Beta Wash. Cemetery			23d. LOCATION CITY OR TOWN Laurel			COUNTY STATE P.G. MD.	
24. FUNERAL DIRECTOR NAME FLECK F.H. INC.			ADDRESS 7601 Sandy Spring Rd. Laurel, MD 20707			25a. DATE REC'D. BY REGISTRAR MAY 2 1986			25b. REGISTRAR'S SIGNATURE June Dawson-Wendell				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 18 is marked or item 18 shows any injury, or other traumatic event, the medical certification must be marked or checked.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO. 12229		
1 - STATE REGISTRAR			1 DECEASED NAME FIRST ANNIE MAE STONE			LAST GREEN			2a. DATE OF DEATH APR 22 86			2b. HOUR 6:45am		
1 SEX Female			4 RACE Black			5. DATE OF BIRTH MONTH Feb. DAY 7 YEAR 1924			6 AGE (IN YEARS LAST BIRTHDAY) 62 YRS			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) South Carolina			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH Prince George's MD.					
10. CITY OR TOWN OF DEATH Camp Springs			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Malcolm Grow Med. Center - Andrews			12a. USUAL OCCUPATION AFB Homemaker			12b. KIND OF BUSINESS OR INDUSTRY N/A			29010		
13a. STATE South Carolina			13b. COUNTY Lee			13c. CITY OR TOWN Bishopsville			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE 146 Woodlawn Circle 29010		
14. FATHER'S NAME FIRST John			MIDDLE Stone			15. MOTHER'S MAIDEN NAME FIRST Doshia			MIDDLE			LAST Casey		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. 249-34-9107			17. INFORMANT Orsburn Stone			3220 Swann Rd. #203 Suitland, Maryland			ADDRESS		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIAC ARREST												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) RESPIRATORY FAILURE DUE TO, OR AS A CONSEQUENCE OF Respiratory Failure Secondary to Lung CA														
(c) DUE TO, OR AS A CONSEQUENCE OF														
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)														
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE								
22a. I certify that (I) (the hospital) attended the deceased from 14 APR 1986 to 22 APR 1986, that (I) (we) last saw the deceased alive on 22 APRIL 1986, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.														
22b. SIGNATURE DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> DATE SIGNED 4/22/86														
22c. PHYSICIAN'S NAME (TYPE OR PRINT) TSU, HORACE			22d. ADDRESS MALCOLM GROW USAF MED CEN, ANDREWS AFB, MD											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Removal			23b. DATE 4/22/86			23c. NAME OF CEMETERY OR CREMATORIAL St. Paul Cemetery			23d. LOCATION CITY OR TOWN Wysacky			COUNTY South Carolina STATE		
24. FUNERAL DIRECTOR NAME George P. Kalas Funeral Home Oxon Hill, Md.			ADDRESS 6160 Oxon Hill Rd.			25a. DATE REC'D. BY REGISTRAR APR 24 1986			25b. REGISTRAR'S SIGNATURE					

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Page 1 of 1 | Last updated: Sep 21, 2023

Scallop Cottages U.S.A. Purple Gables, a

Castro, Rodriguez, Majotw Grom Mag. Center - Superior, etc., Pococer, etc.

3520 Second St., San Jose, Calif. 95112
Phone 361-3714

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Age 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or if item 18 shows any injury, or other traumatic event, the medical examiner should be notified at once.

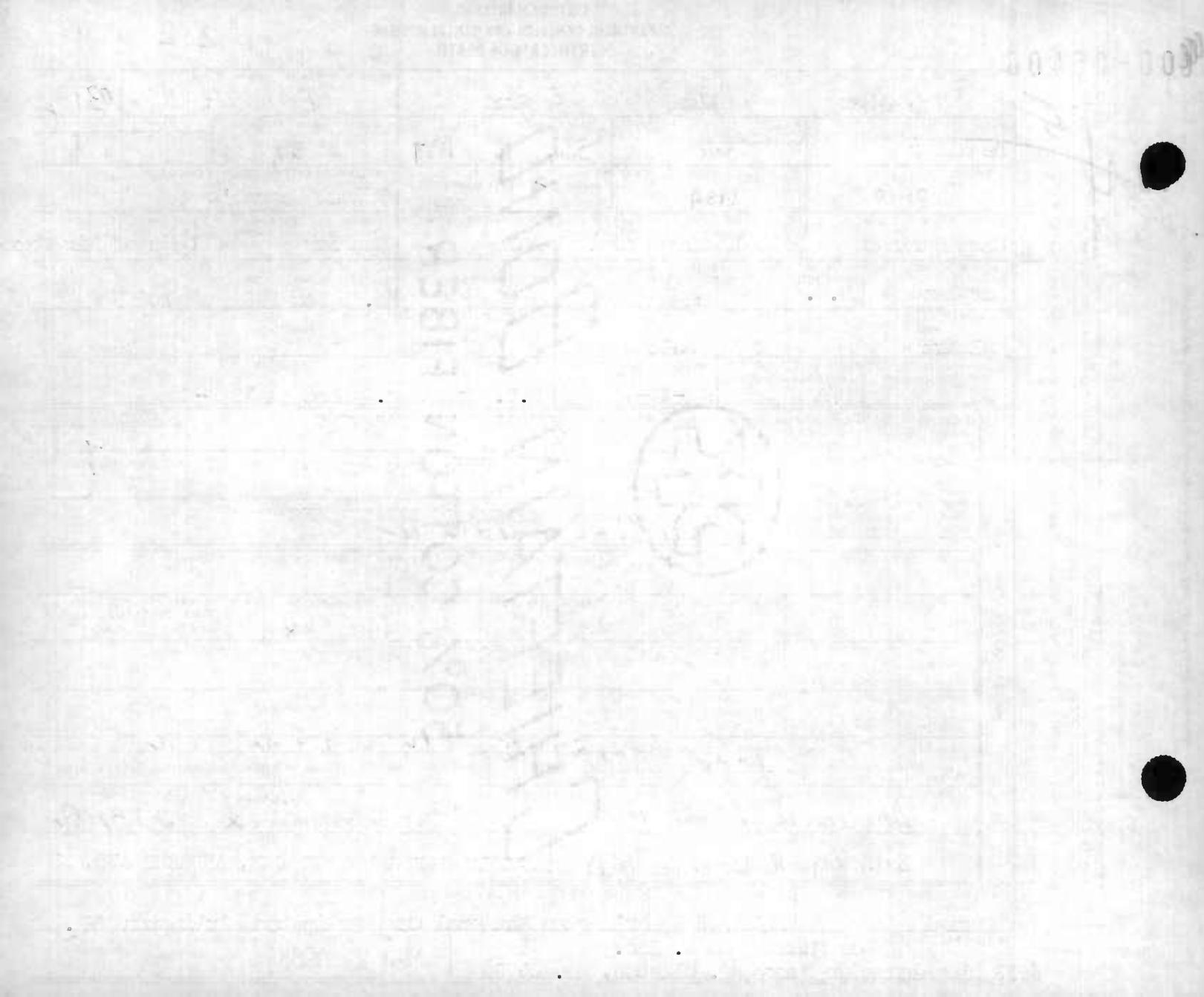
MEDICAL CERTIFICATION

1 - STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 2230

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a DATE OF DEATH	MONTH	DAY	YEAR	2b HOUR		
Gre Mary				Ellen	E Green	April 27, 1986				0317 pm		
3. SEX			4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)			7. IF UNDER 1 YEAR			
Female F			Caucasian auc.	MONTH July	DAY 16	YEAR 1927	58	58 yrs	MONTHS	DAYS	IF UNDER 24 HRS	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH				
OHIO			USA		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			Prince George's MD.				
10 CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			
Camp Springs			Malcolm Grow Hospital AAFB						Cashier			
13a. STATE			13b. COUNTY	13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE				
Maryland			P.G.	Mechanicsville				Rt. 5 Box 206 20659				
14. FATHER'S NAME FIRST			MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST			MIDDLE	LAST			
Albert				Welters	Gladys			Lucille	Gray			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES OR NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.		17. INFORMANT			18. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
No			N/A		269-24-8800			R.C. Green Sr. Same as 13 A-E				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u>												
DUE TO, OR AS A CONSEQUENCE OF <u>DIABETIC KETOACIDOSIS</u> (b) <u>Diabetic Ketoacidosis</u>												
DUE TO, OR AS A CONSEQUENCE OF <u>METASTATIC BREAST CANCER</u> (c) <u>Metastatic Breast cancer</u>												
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)												
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET			CITY OR TOWN	COUNTY	STATE		
22a. I certify that (I) (this hospital) attended the deceased from <u>27 Apr</u> , 19 <u>86</u> , to <u>27 Apr</u> , 19 <u>86</u> , that (I) (we) last saw the deceased alive on <u>27 Apr</u> , 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.												
22b. SIGNATURE <u>Shirley R Lockie MD</u>			DEGREE			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> PHYSICIAN <input checked="" type="checkbox"/>			22c. DATE SIGNED <u>27 Apr 86</u>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Shirley R Lockie MD</u>			22e. ADDRESS			MALCOLM GROW USAF MED CEN, ANDREWS AFB, MD						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL		23d. LOCATION CITY OR TOWN			COUNTY	STATE	
Burial			05/01/86		Arlington National Cem.		Arlington			Arlington	VA.	
24. FUNERAL DIRECTOR NAME			Lee Funeral Home, Inc.						25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE
6683 Old Alexander Ferry Rd. Clinton, Md. 20735									MAY 2 1986			June Hudson Pendleton



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial/tranquill permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked as Item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 12231

1. DECEASED NAME (TYPE OR PRINT)			FIRST NORMAN	MIDDLE KENNETH	LAST GREEN	2a DATE OF DEATH APRIL 21, 1986	MONTH APRIL	DAY 21	YEAR 1986	2b HOUR 2:50 P.M. M	
3. SEX MALE			4. RACE CAUCASIAN			5. DATE OF BIRTH MONTH DAY YEAR May 1, 1935			6. AGE (IN YEARS LAST BIRTHDAY) 50 YRS		
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington, DC			7b CITIZEN OF WHAT COUNTRY? USA			8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGES COUNTY MD.		
10. CITY OR TOWN OF DEATH CLINTON			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION SOUTHERN MD. HOSP. CTR.			12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Plumber			12b. KIND OF BUSINESS OR INDUSTRY U. S. Govt.		
13a. STATE MD			13b. COUNTY Pr. Geo.	13c. CITY OR TOWN Accokeek	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e STREET ADDRESS / ZIP CODE 15857 Livingston Rd / 20607			
14. FATHER'S NAME FIRST Robert			MIDDLE Allen	LAST Green	15. MOTHER'S MAIDEN NAME FIRST Marie			MIDDLE Henning	LAST		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes			16b. SOCIAL SECURITY NO. 1958 - 1963 579-46-3081			17. INFORMANT Spouse			ADDRESS GAINELL M. GREEN same as 13		
18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)			Cardiorespiratory failure						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 24 hrs		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last			(b) Cerebral Edema						84 hrs		
			(c) pneumococcal meningitis						5 days		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a Hypertensive cardiovascular disease Diabetes mellitus											
19a. DATE OF OPERATION NA			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN	COUNTY	STATE
22a. I certify that (1) (this hospital) attended the deceased from <u>one 4/26/86</u> to <u>4/21/86</u> , that (1) (we) last saw the deceased alive on <u>4/26/86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) (did) (did not) view the body at death.											
22b. SIGNATURE 			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 4/24/86		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DAVID N. ROBB MD			22e. ADDRESS 9401 Indian Head Hwy Ft. Washington						20344		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 4/26/86			23c. NAME OF CEMETERY OR CREMATORIAL Trinity Memorial			23d. LOCATION CITY OR TOWN Waldorf, Charles, MD		
24. FUNERAL DIRECTOR NAME Huntt Funeral Home, Waldorf, MD			ADDRESS			25a. DATE REC'D. BY REGISTRAR APR 25 1986			25b. REGISTRAR'S SIGNATURE Julia Davison		

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL ALONG PAGE 4. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PW-3 RETAIN PAGE 5 FOR YOUR FILES.

TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												1 2 2 3 2							
												REG. NO.							
1 - STATE REGISTRAR		I. DECEASED NAME (TYPE OR PRINT)			FIRST			MIDDLE			LAST			2a. DATE KNOWN OF DEATH ESTIMATED	<input checked="" type="checkbox"/>	MONTH	DAY	YEAR	2b. HOUR
		Loretta			K.						Grindstaff			4-9	<input type="checkbox"/>	19	86	M	
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YR. MONTHS DAYS HOURS MIN.			2c. DATE PRONOUNCED DEAD		MONTH DAY YEAR			2d. HOUR	
Female		White		Jan. 18 60 26			YRS.						4-9		19 86			p.m.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?										MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			
Tenn.		U.S.A.														Prince George's County, MD.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)										12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY					
Clinton		10205 Pine Meadow Lane										Waitress		Restaurant					
13a. STATE		13b. COUNTY		13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS									
Md.		Prince George		Landover						4212 71st. Ave. 20784									
14. FATHER'S NAME FIRST		MIDDLE			LAST			15. MOTHER'S MAIDEN NAME FIRST		MIDDLE			LAST						
Glenn		H.			Grindstaff			Mary					Hodge						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		16c. INFORMANT			17. ADDRESS		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) _____ DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH								
		213-78-8883		Glenn H. Grindstaff Mt. Rainier, Md.															
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?										20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR ? P.M. 4-9 1986			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) subject shot herself			21d. LOCATION STREET 10205 Pine Meadow Lane, Clinton, Prince George's Co., Md.				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) Home							
21f. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>		21g. TITLE (SPECIFY) Assistant			21h. MEDICAL EXAMINER			21i. COUNTY				21j. STATE							
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																			
ACTUAL SIGNATURE																DATE SIGNED 4-10-86			
EXAMINER'S NAME (TYPE OR PRINT)		Dennis F. Smyth, M.D.			ADDRESS 111 Penn St., Balto., Md. 21201														
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE 4-13-86			23c. NAME OF CEMETERY OR CREMATORIAL Butler Memorial			23d. LOCATION CITY OR TOWN Butler		23e. COUNTY Tenn.		23f. STATE Tenn.							
24. FUNERAL DIRECTOR NAME		ADDRESS						25a. DATE REC'D. BY REGISTRAR APR 15 1986		25b. REGISTRAR'S SIGNATURE									
Henry W. Jenkins & Sons Co., Balto., Md.																			

1. *U* *U* *U*
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO. 12233			
1. FOR STATE REGISTRAR			FIRST CRISSIE			MIDDLE ANN			LAST HAIRSTON			2a. DATE OF DEATH 04-30-86		2b. HOUR 2 : 20PM	
1. DECEASED NAME (TYPE OR PRINT)			4 RACE MAILE			5. DATE OF BIRTH MONTH DAY YEAR 1 28 05			6. AGE (IN YEARS LAST BIRTHDAY) 81 YRS			IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Leakesville, N.C.			7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGE'S COUNTY MD.						
10. CITY OR TOWN OF DEATH CHEVERLY			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION PRINCE GEORGE'S GENERAL HOSPITAL			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired, Forest Haven			12b. KIND OF BUSINESS OR INDUSTRY D.C. Govt.						
13a. STATE Md.			13b. COUNTY			13c. CITY OR TOWN Capitol Hights			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS 110 East Mill Avenue			
14. FATHER'S NAME Stokes			MIDDLE LAST Wilson			15. MOTHER'S MAIDEN NAME Nicel			16. SOCIAL SECURITY NO. 579-64-6210						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. 579-64-6210			17. INFORMANT			ADDRESS Mrs. Marie Hawkins/daughter/same as 13e						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardio pulmonary arrest</u>												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Atherosclerotic heart disease</u>															
DUE TO, OR AS A CONSEQUENCE OF (c) <u>Recurrent systemic infections</u>															
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>Recurrent systemic infections</u>															
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY		STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>3/10</u> , 19 <u>76</u> , to <u>4/30</u> , 19 <u>76</u> , that (I) (we) last saw the deceased alive on <u>4/29</u> , 19 <u>76</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.															
22b. SIGNATURE <u>Ronald M. Henry MD</u>			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED <u>5/1/86</u>						
22d. PHYSICIAN'S NAME (TYPE OR PRINT) RONALD M. HENRY, M.D.			22e. ADDRESS 7603 GEORGIA AVE. N.W. WASH. D.C.												
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 5-5-86			23c. NAME OF CEMETERY OR CREMATORIAL Harmony Memorial			23d. LOCATION CITY OR TOWN Lanover, Md.			COUNTY		STATE	
24. FUNERAL DIRECTOR NAME John T. Rhines Co., 3015 12th St. N.E., D.C.			ADDRESS MAY 7 1986			25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE <u>Johanna Davidson</u>									

YTMED 210000Z 30 SEP 94

ATLANTIC BOUNDARY DRAFT

1000Z 29 SEP

1000Z 30 SEP

Blessed by Dr. Rodriguez

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 8 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

1 - FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 86 12234

1. DECEASED NAME (TYPE OR PRINT)			FIRST ALOYSIUS MIDDLE JOSEPH LAST HALL ALOYSIUS J. HALL			2. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR		
3. SEX Male			4. RACE Caucasian			5. DATE OF BIRTH MONTH 6 DAY 24 YEAR 02	6. AGE (IN YEARS LAST BIRTHDAY) 83 YRS.			IF UNDER 1 YEAR MONTHS	IF UNDER 24 HRS. HOURS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD			7b. CITIZEN OF WHAT COUNTRY? USA			MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's Co. MD.					
10. CITY OR TOWN OF DEATH Clinton			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (DO NOT IN SUCH FACILITY, GIVE STREET ADDRESS) St. Maryland Hospital			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Farmer			12b. KIND OF BUSINESS OR INDUSTRY Agriculture			
13a. STATE MD			13b. COUNTY PR. GEO.	13c. CITY OR TOWN CHELTENHAM	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE General Delivery / 20623				
14. FATHER'S NAME FIRST Robert MIDDLE Lee LAST Hall			15. MOTHER'S MAIDEN NAME Alice Elizabeth Campbell									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. 217-60-9223			17. INFORMANT Niece Marguerite H. Suite Oaks Pl., Laurel			ADDRESS 8335 Snowden			
18. CAUSE OF DEATH (Enter only one cause per line for 18a, 18b, and 18c.) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)			ACUTE MASSIVE ISCHEMIC STROKE						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH MD DAYS.			
Conditions, if any, which gave rise to immediate cause 18a, stating the underlying cause lost			(b) ATHEROSCLEROTIC CEREBRAL ARTERIOSCLEROSIS						YEARS.			
			(c) ATHEROSCLEROTIC CARDIOVASCULAR DISEASE						YEARS.			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1b RIGHT SIDE HEMIPARESIS AND EXPRESIVE APHASIA, MASSIVE TRANSAMINITIS.												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/>				
21d. INJURY OCCURRED WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from APRIL 20, 1986, to APRIL 21, 1986, that (I) (we) last saw the deceased alive on APRIL 21, 1986, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE <i>Peter W. Yim M.D.</i>			DEGREE M.D.			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED APRIL 21 1986			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) PETER W. YIM M.D.			22e. ADDRESS 7900 OLD BRANCH AVE. SUITE 101 CLINTON MARYLAND 20735									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 4/25/86			23c. NAME OF CEMETERY OR CREMATORIUM Hall Family Cemetery Cheltenham, PR. GEO, MD			23d. LOCATION CITY OR TOWN COUNTY STATE			
24. FUNERAL DIRECTOR NAME HUNTT FUNERAL HOME, WALDORF, MD			25a. DATE REC'D. BY REGISTRAR APR 24 1986			25b. REGISTRAR'S SIGNATURE						

J17 0-00

MANUFACTURERS

66000 43 2868

66000 43 2868

00-05376

FOR
1 - STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH22355
REG. NO.

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 8. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 21201 BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

1. DECEASED NAME (TYPE OR PRINT)		FIRST <i>Dorothy</i>	MIDDLE <i>Lee</i>	LAST <i>JAMES HAL</i>	2a DATE KNOWN OF ESTI- DEATH MATED	1 MONTH DAY YEAR <i>4-23 1986</i>	2b HOUR
3. SEX <i>Female</i>	4. RACE <i>Black</i>	5. DATE OF BIRTH MONTH DAY YEAR <i>May 26, 1934</i>		6 AGE (IN YEARS LAST BIRTHDAY) <i>51 yrs.</i>	7 IF UNDER 1 YR. MONTHS <i> </i>	8 IF UNDER 24 HRS. HOURS <i> </i>	9 DATE PRONOUNCED DEAD <i>4-23 1986</i>
10. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>North Carolina</i>		7b CITIZEN OF WHAT COUNTRY? <i>United States</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Prince Georges County</i>	
10. CITY OR TOWN OF DEATH <i>Clinton</i>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (NOT IN SURGEON FACILITY, GIVE STREET ADDRESS) <i>Southern Maryland Hospital</i>		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Homemaker</i>		12b KIND OF BUSINESS OR INDUSTRY <i>Domestic</i>	
13a STATE <i>Maryland</i>		13b. COUNTY <i>Prince Georges</i>	13c CITY OR TOWN <i>Clinton</i>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e STREET ADDRESS <i>4921 Plata Street, (20735)</i>		
14. FATHER'S NAME FIRST <i>Clarence</i>		MIDDLE <i> </i>	LAST <i>James</i>	15. MOTHER'S MAIDEN NAME FIRST <i>Eliza</i>		MIDDLE <i>Mae</i>	LAST <i>Beach</i>
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <i>No</i>		16b. SOCIAL SECURITY NO. <i>242-50-1510</i>		17. INFORMANT <i>Dianna Pearson (daughter)</i>		18. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i> </i>	
<p>18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)</p> <p>PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Diabetic arteriosclerotic cardio-renal vascular disease</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) <i> </i> DUE TO, OR AS A CONSEQUENCE OF (c) <i> </i></p> <p>PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).</p>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20 AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <i>19</i>	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
<p>22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/></p> <p>ACTUAL SIGNATURE <i>Douglas J. Roddy, Jr. M.D.</i> TITLE (SPECIFY) <i>Deputy Medical Examiner</i> EXAMINER'S NAME (TYPE OR PRINT) <i>Winston P. Roddy, Jr. M.D.</i> ADDRESS <i>5209 Paynter St., LaGrange, NC 27749</i> DATE SIGNED <i>4-23-86</i></p>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>04/27/86</i>	23c. NAME OF CEMETERY OR CREMATORIAL <i>Evergreen Cemetery</i>		23d. LOCATION CITY OR TOWN <i>Winston-Salem, Forsyth County, North Carolina</i>	23e. DATE REC'D. BY REGISTRAR <i> </i>	
24. FUNERAL DIRECTOR NAME <i>LATNEY's Funeral Home</i>		ADDRESS <i>3831 Georgia Avenue, NW; Washington, DC 20011</i>	25a. DATE REC'D. BY REGISTRAR <i> </i>		25b. REGISTRAR'S SIGNATURE <i>John Roddy</i>		

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death of a patient be reported by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be detached for use at the funeral director's permit. Then please remove carbon paper. Pages 1 and 2 could be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial; cremation or removal.

IMPORTANT: If item 21 is marked with a checkmark, then item 18 shall carry injury or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 0 0 1 2 2 3 6			
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			20. DATE OF DEATH MONTH DAY YEAR			2b HOUR				
Emma Marguerite HALL						April 3, 1986			12:30am				
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.			
Female		White		July 30, 1895			90 YRS.			IF UNDER 24 HRS			
7a BIRTHPLACE COUNTRY		7b CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Prince-Georges MD						
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		10. CITY OR TOWN OF DEATH Hyattsville			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Sacred Heart Home, Inc.			12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Clerical Wk., USDept.of Treasury					
13a STATE Maryland		13b COUNTY Prince-Georges		13c. CITY OR TOWN Hyattsville			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e STREET ADDRESS / ZIP CODE 2000 Tuckerman Street 20782			
14. FATHER'S NAME FIRST Charles		MIDDLE Klier		15. MOTHER'S MAIDEN NAME Estelle			16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO			16b SOCIAL SECURITY NO. 578-54-9768			
17. INFORMANT DOLORES L. KRANKING, 6700 23rd AVE Hyatt. MD			ADDRESS			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH day				
DUE TO, OR AS A CONSEQUENCE OF (b) Chronic organic brain syndrome						(c)			years				
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a Hypertension, Parkinson disease													
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b PART 1 OR PART 2)								
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f LOCATION STREET CITY OR TOWN COUNTY STATE								
22a I certify that (I) (the hospital) attended the deceased from saw the deceased alive on 4/2 19 86 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (do) (did) (did not) view the body after death.										22c DATE SIGNED 4/3/1986			
22b. SIGNATURE Byrl D. Johnson		DEGREE MD			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>								
22d. PHYSICIAN'S NAME (TYPE OR PRINT) BYRL D. JOHNSON, M.D.		22e. ADDRESS 4404 Queensbury Rd. Riverdale, Md.											
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE APRIL 7. 1986		23c. NAME OF CEMETERY OR CREMATORIUM Fort Lincoln Cemetery			23d. LOCATION CITY OR TOWN Brentwood MD						
24 FUNERAL DIRECTOR NAME Takoma Funeral Home, J. Walter		ADDRESS 254 Carroll St NW DC			25e. DATE REC'D. BY REGISTRAR / REGISTRAR'S SIGNATURE APR 7 1986 Julian Wilson Pendell								

0001 - C LIMA

LEAD

RECOMMEND

ARMED

OR

CONFIDENTIAL

REF ID:

910001

CONFIDENTIAL

X

REF ID:

910001

TYPE OF INFORMATION REQUESTED

REF ID: 910001

ALL INFORMATION

CONFIDENTIAL 0002

X CONFIDENTIAL COORDINATED INFORMATION

AMM

REF ID:

910001

ON THIS SUBJECT OF A PLACEMENT IN THE 5000-6000

OK

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AM 09 1968 PLACEMENT REQUESTED 100-200-500-2000

AMERICAN BANK AND TRUST COMPANY

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial permit. Then please sign and file it along with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										1 2 2 3 1			
										REG. NO.			
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a DATE OF DEATH		MONTH	DAY	YEAR	2b HOUR		
<i>BETTY LOU Hammock</i>						03		31	86	9:30 PM			
3. SEX			RACE	5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS			
FEMALE			BLACK	MARCH 1 1891		95		MONTHS DAYS		HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH						
MISSISSIPPI			U.S.A.				PRINCE GEORGES MD.						
10 CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY						
CLINTON			Southern Md Hospital NURSE										
13a. STATE			13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE		20748				
MD.			P.G.	TEMPLE HILLS			3303-28th Parkway						
14. FATHER'S NAME			FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME		Ross					
John Harrington						Sophia		LAST					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, UNKNOWN)			16b. SOCIAL SECURITY NO		17. INFORMANT		ADDRESS						
NO			110-22-0693		Katherine Eggleton (wife of Temple Hills, MD.)		3303-28th Parkway						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Congestive heart failure</i>										ADDITIONAL MATERIAL BETWEEN ONSET AND DEATH			
DUE TO, OR AS A CONSEQUENCE OF <i>A fatigued coronary of lung</i>													
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost													
DUE TO, OR AS A CONSEQUENCE OF (c)													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. <i>AS HT - Anemia - cardiac arrhythmia</i>													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from 3/31 1986 to 3/31 1986, that (I) (we) lost sow the deceased alive on 3/31 1986, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										22c. DATE SIGNED 4/11/86			
22b. SIGNATURE <i>R. mostaan</i>			22d. DEGREE				ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>						
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>REZA MOSTAAN</i>			22e. ADDRESS 4235 28th St. and 20748										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>BURIAL</i>			23b. DATE <i>4-4-86</i>		23c. NAME OF CEMETERY OR CREMATORIUM <i>Fort Lincoln Cem.</i>		23d. LOCATION CITY OR TOWN <i>Brentwood P.G. MD.</i>		STATE				
24. FUNERAL DIRECTOR NAME <i>Robert G. Mason</i> ADDRESS <i>1661 Good Hope Rd., S.E., Wash., D.C.</i>			25a. DATE REC'D. BY REGISTRAR <i>APR 15 1986</i>				25b. REGISTRAR'S SIGNATURE <i>Robert G. Mason</i>						

POSITIONING ELEVEN



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be filed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be detached for use as the burial/transit permit. Then please remove carbon from the first page. This page should be filed within 24 hours after death. Page 4 may be retained by the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked "D" show any injury, or other traumatic event the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												1 2 2 3 8							
												REG. NO.							
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2d. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR							
John			N.	Hanchak		April 4, 1986						9:45P M							
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS.							
M-		White		May 24, 1897			88			YRS.		MONTHS DAYS HOURS MIN.							
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH			MD.									
Pennsylvania		USA					Prince Georges County												
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)										12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY					
Laurel		Greater Laurel Beltsville Hospital										electrician		coal mine					
13a. STATE Md												13b. COUNTY Prince George		13c. CITY OR TOWN Laurel		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 11504 Basswood Ct 20708	
14. FATHER'S NAME FIRST		MIDDLE		LAST			15. MOTHER'S MAIDEN NAME FIRST			LAST									
Nicholas				Hanchak			Eva			Pendrick									
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES OR NO OR UNKNOWN)			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)			17. INFORMANT			ADDRESS										
yes			WW I			162 05 8225			John Hanchak, Jr same as above										
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
<i>CARDIOPULMONARY FAILURE</i>																			
DUE TO, OR AS A CONSEQUENCE OF (b) <i>PNEUMONIA · HYPERTENSIVE HEART DISEASE</i>																			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause, lost. (c) <i>Congestive Heart failure</i>																			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>Probable Acute Cholecystitis</i>																			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?											
					YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>											
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)														
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY	STATE								
22a. I certify that (I) (this hospital) attended the deceased from 4/31/1986 to 4/4/1986, that (I) (we) last saw the deceased alive on 4/31/1986, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.																			
22b. SIGNATURE <i>Abdul Nayeem MD</i>		DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/>			MEDICAL DIRECTOR <input type="checkbox"/>		STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 4/5/86							
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>ABDUL NAYEEM</i>		22e. ADDRESS <i>3430 Fort Meade Road, LAUREL, MD 20707</i>																	
23a. BURIAL, CREMATION, REMOVAL Burial		23b. DATE April 7, 1986		23c. NAME OF CEMETERY OR CREMATORIAL St. Johns Cemetery			23d. LOCATION Mayfield, Pa			COUNTY		STATE							
24. FUNERAL DIRECTOR NAME Donaldson Funeral Home, Laurel, Md		ADDRESS			25a. DATE REC'D. BY REGISTRAR APR 14 1986			25b. REGISTRAR'S SIGNATURE <i>Julia Davidson-Nordell</i>											

20280-0



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached to cover the burial permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as having any injury or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO. 12239		
1. FOR STATE REGISTRAR			I. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR		
			KENNETH Paul HAUGHEE						04 09 86			8 P.M.		
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		
Male			Caucasian			July 23 1941			44			MONTHS DAYS		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8			9. BALTIMORE CITY OR COUNTY OF DEATH			IF UNDER 24 HRS		
Gary, Ind.			USA			MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>			PRINCE GEORGE COUNTY MD.			HOURS MIN.		
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY					
CHEVERLY			PGG HOSPITAL AND MEDICAL CENTER			Comp. Engineer			Computers					
13a. STATE Md.			13b. COUNTY A.A.			13c. CITY OR TOWN Crofton			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE 906 Eastham Ct. 21114		
14. FATHER'S NAME FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST											
John Alexander Haughee			Emma Alice Henry									ADDRESS 580 Manor Rd.		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (IF YES, GIVE WAR OR DATES) yes			16b. SOCIAL SECURITY NO. 310-44-3996			17. INFORMANT Paul A. Haughee Severna Pk., Md.								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiopulmonary arrest</u>													APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.													(b) <u>Subarachnoid hemorrhage</u>	
													(c) <u>and Hydrocephalus</u> <u>Ruptured Intracranial Aneurysm</u>	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a														
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR, CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE								
22a. I certify that (I) (this hospital) attended the deceased from <u>417</u> , 19 <u>86</u> , to <u>419</u> , 19 <u>86</u> , that (I) (we) last saw the deceased alive on <u>19</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													22c. DATE SIGNED 4/10/86	
22b. SIGNATURE <u>Najmaldin O. Karim M.D.</u>			22c. DEGREE M.D.			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>								
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Najmaldin O. Karim			22e. ADDRESS 7500 Hanover Pkwy # 204 Greenbelt MD.											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation			23b. DATE 4/12/86			23c. NAME OF CEMETERY OR CREMATORIAL Balto. Wash. Crematory Laurel			23d. LOCATION Laurel P.G. Md.					
24. FUNERAL DIRECTOR NAME FLECK F.H. INC.			ADDRESS 7601 Sandy Spr. Rd.			25a. DA1. REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE Jackson Pendell					
												APR 15 1986		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 18 shows any injury, or other traumatic event, the medical examiner must be informed.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH													
3 6 1 2 2 4 0													
00-05072	REG. NO.												
1 - FOR STATE REGISTRAR			I DECEASED NAME			FIRST MIDDLE LAST			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR	
			John Lester HAYDEN						April 25, 1986			9:34 P.M.	
3. SEX Male			4. RACE Caucasian			5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR	
						5-29-1899			86			MONTHS DAYS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH Prince George's MD.				
10 CITY OR TOWN OF DEATH Lanham			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Doctor's Hospital			12a. USUAL OCCUPATION			12b. KIND OF BUSINESS OR INDUSTRY				
13a. STATE Maryland			13b. COUNTY P.G.			13c. CITY OR TOWN Bladensburg			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE 4407 56th Ave., 20710	
14. FATHER'S NAME FIRST Charles			MIDDLE			LAST Hayden			15. MOTHER'S MAIDEN NAME Selenia			Wise 5 st	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES OR UNKNOWN) No			(IF YES, GIVE WAR OR DATES) -----			16b. SOCIAL SECURITY NO. 578-10-5918			17. INFORMANT			ADDRESS	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:			IMMEDIATE CAUSE (a)			SEPTICEMIA						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause last.			(b)			DUE TO, OR AS A CONSEQUENCE OF ACUTE RENAL FAILURE							
			(c)			DUE TO, OR AS A CONSEQUENCE OF CONGESTIVE HEART FAILURE							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a													
CORONARY ARTERY DISEASE, RECENT MYOCARDIAL INFARCTION.													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?				
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> X			YES <input type="checkbox"/> NO <input type="checkbox"/> X				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from 4/19/86 to 4/25/86, that (I) (we) last saw the deceased alive on 4/25/86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE <i>V.P. Singh</i>			22c. DEGREE M.D.			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			DATE SIGNED 4/26/86				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Virender P. Singh M.D.			22e. ADDRESS 5632 Annapolis Rd., Bladensburg, Md. 20710										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 4-28-1986			23c. NAME OF CEMETERY OR CREMATORIAL Ft. Lincoln Cem.			23d. LOCATION Brentwood, P.G., Maryland				
24. FUNERAL DIRECTOR NAME Francis Gasch's Sons, P.A.			ADDRESS						25a. DATE REC'D. BY REGISTRAR APR 29 1986			25b. REGISTRAR'S SIGNATURE <i>J. Gasch</i>	

31020-00

CANDY



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked, or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

00-04965

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 2241

1. FOR STATE REGISTRAR			2. DATE OF DEATH MONTH DAY YEAR										3. HOUR								
I. DECEASED NAME (TYPE OR PRINT)			FIRST			MIDDLE			LAST			4. DATE OF DEATH		MONTH		DAY		YEAR		5. HOUR	
<i>HAZEL Louise HAYNES</i>									<i>HAZEL Louise HAYNES</i>			<i>4-25-86</i>		APR		28		1986		<i>4:50 AM</i>	
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			7. IF UNDER 1 YEAR		8. IF UNDER 24 HRS							
Female			Caucasian			Month Jan Day 8, Year 1919			67			MONTHS		DAYS		HOURS		MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			<i>Pawtucket, Rhode Island Co. MD.</i>									
Maryland			U.S.A.																		
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY												
Clinton			<i>St. MARYLAND Hospital</i>			<i>Homemaker</i>			<i>Home</i>												
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)			13b. COUNTY			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE												
13a. Maryland			13b. Charles			13d. Waldorf			13e. 2000 Amber Leaf Pl #T-7												
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME			16. SOCIAL SECURITY NO.			17. INFORMANT												
FIRST Arthur MIDDLE E. LAST Cusick			FIRST Beulah MIDDLE L. LAST Horton			16b. 578-38-7099			17. William B. Haynes												
18a. WAS DECEASED EVER IN U.S. ARMED FORCES? (IF NO OR UNKNOWN) <input type="checkbox"/> (IF YES, GIVE WAR OR DATES)			18b. ADDRESS			18c. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH															
No																					
18c. PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)			18d. CARDIOVASCULAR ANEST			18e. Minutes															
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			18f. DUE TO OR AS A CONSEQUENCE OF (b) EPIDEMIC CARCINOMA OF LUNG			18g. 4 years															
18h. DUE TO, OR AS A CONSEQUENCE OF (c)																					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a																					
19a. CHRONIC OBSTRUCTIVE LUNG DISEASE			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>												
19a. DATE OF OPERATION			19b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			20a. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)															
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21c. LOCATION STREET CITY OR TOWN COUNTY STATE															
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. LOCATION STREET CITY OR TOWN COUNTY STATE																		
22a. I certify that (I) (this hospital) attended the deceased from <i>4/22/86</i> to <i>4/29/86</i> , to <i>4/30/86</i> , that (I) (we) last saw the deceased alive on <i>4/22/86</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.																					
22b. SIGNATURE: <i>DK</i>			22c. DEGREE			22d. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22e. DATE SIGNED <i>4/25/86</i>												
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Louis Kaufman, M.D.</i>			22e. ADDRESS <i>8926 Woodyard Road #602 Clinton, MD 20735</i>																		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>			23b. DATE <i>4-28-86</i>			23c. NAME OF CEMETERY OR CREMATORIAL <i>Arlington Nat. Cem.</i>			23d. LOCATION <i>Arlington, Arlington, Va.</i>												
24. FUNERAL DIRECTOR <i>Hunt Funeral Home</i>			25a. ADDRESS <i>P. O. Box 156 Waldorf, Md. 20601</i>			25b. DATE REC'D. BY REGISTRAR <i>APR 28 1986</i>			25b. REGISTRAR'S SIGNATURE <i>Julie Saideon-Pandrea</i>												

3

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use on the burial/transit permit. Then please remove carbon paper pages, and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on Item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO. 12242					
1- STATE REGISTRAR			FIRST			MIDDLE			LAST			2a DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)			Vera						Haya			04-03-86				5P M	
2. SEX			4 RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR			IF OVER 24 HRS		
Female			Caucasian			MONTH DAY YEAR			83			MONTHS DAYS			HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8			MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH			MD.		
Sweden			USA			05-27-1902			Prince Georges Co								
10 CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			13d INSIDE CITY LIMITS?			12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY					
College Park			9014 Rhode Island Ave.			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			Housewife			AT HOME					
13c. STATE			13b. COUNTY			13c. CITY OR TOWN			13e. STREET ADDRESS / ZIP CODE			20740					
Maryland			P.g.			Colleges Park			1014 Rhode Island Ave.								
14. FATHER'S NAME			LAST			15. MOTHER'S MAIDEN NAME			ADDRESS			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
FIRST			Scasttedt			FIRST			Amanda			LAST			11 mos..		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			(Son) William J. HAYO (Same)								
NO			123-14-0253														
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Breast cancer with bony metastases</u>																	
DUE TO, OR AS A CONSEQUENCE OF (b) _____																	
DUE TO, OR AS A CONSEQUENCE OF (c) _____																	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?								
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>April</u> , 19 <u>85</u> , to <u>April</u> , 19 <u>86</u> , that (I) (we) last saw the deceased alive on <u>April</u> , 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																	
22b. SIGNATURE <u>La-Yin Yeng, M.D.</u>			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 4-4-86								
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>La-Yin Yeng, M.D.</u>			22e. ADDRESS <u>8926 Woodard Rd # 201 Clinton, MD 20735</u>														
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE <u>4-4-1986</u>			23c. NAME OF CEMETERY OR CREMATORY <u>CHAMBERS CREMATORIUM</u>			23d. LOCATION CITY OR TOWN <u>RIVERDALE, PG.C., Md.</u>			25a. DATE REC'D. BY REGISTRAR <u>APR 10 1986</u>			25b. REGISTRAR'S SIGNATURE <u>Jeanne Smith</u>		
24. FUNERAL DIRECTOR NAME <u>W.W. CHAMBERS Co.</u>			ADDRESS <u>RIVERDALE, Md.</u>														
DHMH - 16 60M 7/84 (VRA 15, 4)																	

31560-00

(and) continuing to do
what you have done

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be detached for use as the burial transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours in your office with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. If item 21 is marked "No" there is no injury, or other traumatic event. The medical examiner will be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					
1. FOR STATE REGISTRAR			8 REC'D.	1	2
2. DECEASED NAME (TYPE OR PRINT)			2a. DATE OF DEATH	MONTH	DAY
Alfred Joseph Heine			Jan. 21, 1986	4	7
3. SEX MALE			4. RACE Caucasian	5. DATE OF BIRTH MONTH DAY YEAR Jan. 21, 1904	6. AGE (IN YEARS LAST BIRTHDAY) 82 YRS
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) North Dakota			7b. CITIZEN OF WHAT COUNTRY? USA	MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	7c. IF UNDER 1 YEAR MONTHS DAYS
10. CITY OR TOWN OF DEATH Lanham			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Doctor's Hospital of P. G. Co.		
12. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13. STATE Maryland			13b. COUNTY Pr George's	13c. CITY OR TOWN Bowie	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST Joseph			MIDDLE Alfred	LAST Heine	15. MOTHER'S MAIDEN NAME FIRST Barbara
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. 225-10-1484	17. INFORMANT Iona M. Heine	18e. STREET ADDRESS / ZIP CODE 12819 9th Street 20715
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio-Pulmonary Arrest.			18f. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last			18g. DUE TO, OR AS A CONSEQUENCE OF (b) Heart Block.		
			18h. DUE TO, OR AS A CONSEQUENCE OF (c) 		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (the hospital) attended the deceased from Apr 4, 1986 to 4/7, 1986 , that (I) (we) last saw the deceased alive at 4/7, 1986 , and that in (my) own opinion death occurred on the date and hour and from the causes stated above, (I) know (did) not know (the cause of death).					
22b. SIGNATURE Alford DEGREE					
22c. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) R. SOOP M.D. 22e. ADDRESS 6911 Laurel-Bowie Rd. Bowie Md.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE April 10 1986	23c. NAME OF CEMETERY OR CREMATORIAL Ft. Lincoln Cemetery	23d. LOCATION CITY OR TOWN Brentwood, Maryland	23e. STATE MD
24. FUNERAL DIRECTOR NAME P. Bealy		25a. ADDRESS 16000 Annapolis Road	25b. DATE REC'D. BY REGISTRAR APR 15 1986	25b. REGISTRAR'S SIGNATURE David Pendle	
Beall Funeral Home		Bowie, Maryland			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO. 86 12244	
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR		
ALMETA L. HENDERSON						4/28/86					11:50 pm		
3. SEX Female			4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR Feb. 25, 1933	6. AGE (IN YEARS LAST BIRTHDAY) 53 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) N.C.			7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGE'S COUNTY		MD.					
10. CITY OR TOWN OF DEATH CLINTON			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SOUTHERN MARYLAND HOSPITAL CENTER		12a. USUAL OCCUPATION Housewife		12b. KIND OF BUSINESS OR INDUSTRY Domestic						
13a. STATE Maryland			13b. COUNTY Charles		13c. CITY OR TOWN Brandywine		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE P.O. Box 81 20613				
14. FATHER'S NAME Charles			MIDDLE	LAST	15. MOTHER'S MAIDEN NAME Jessie		FIRST MIDDLE		LAST Kennedy				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 579-48-2860		17. INFORMANT Husband James Henderson P.O. Box 81 Brandywine		ADDRESS				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>cardiopulmonary arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Renal Failure</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Diabetes Mellitus</u>													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>4/26/86</u> , 19 <u>86</u> , to <u>4/29/86</u> , 19 <u>86</u> , that (I) (we) last saw the deceased alive on <u>4/28/86</u> , 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did <input checked="" type="checkbox"/> did not <input type="checkbox"/> view the body after death.													
22b. SIGNATURE <u>William J. Tanenbaum MD</u>		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>4/30/86</u>							
22d. PHYSICIAN'S NAME (TYPE OR PRINT) R. TANENBERG, M.D.		22e. ADDRESS 5711 Allentown Road Camp Springs, Md											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE May 3, 86		23c. NAME OF CEMETERY OR CREMATORIAL Harmony Mem. Park		23d. LOCATION CITY OR TOWN Landover		COUNTY		STATE Maryland			
24. FUNERAL DIRECTOR NAME Hunt Funeral Home		ADDRESS 2801 7th St. N.E. DC		25a. DATE REC'D. BY REGISTRAR MAY 5 - 1986		25b. REGISTRAR'S SIGNATURE <u>J. Hunt</u>							

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use in the burial permit. Then please remove carbon paper. Return 1 and 2 within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 1B shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8612245						
												REG. NO.						
1. FOR STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT)			FIRST		MIDDLE		LAST		2a. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR		
		<u>Helen</u>			MAY				<u>Henshaw</u>		4/13/86					4:58 PM		
3. SEX		4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS					
<u>F Female</u>		White			MONTH 11 DAY 07 YEAR 96			89			YEARS		MONTHS DAYS		HOURS MIN.			
7a. BIRTHPLACE COUNTRY		7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH										
Penn.		USA						P.G Prince George			MD.							
11. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY										
Adelphi		Presidential Woods			Retired			Government			20859							
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE										
MD		Montgomery		Potomac				11800 Charen La			20859							
14. FATHER'S NAME FIRST		MIDDLE			LAST		15. MOTHER'S MAIDEN NAME											
James		Leary					Alice Follett											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (IF UNKNOWN)		16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS										
NO		174-01-8038			Jack B Henshaw			11800 Charen Lane 20854			Potomac Md.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Septic</u>												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u>						
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b). (c)																		
DUE TO, OR AS A CONSEQUENCE OF (b)																		
DUE TO, OR AS A CONSEQUENCE OF (c)																		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a <u>Organic Brain Syndrome</u>																		
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?										
					YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART 1 OR PART 2)													
21d. INJURY OCCURRED <u>WHILE AT HOME</u>		21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.) <u>nursing home</u>			21f. LOCATION STREET			CITY OR TOWN		COUNTY		STATE						
22a. I certify that (I) (this hospital) attended the deceased from <u>11/13</u> , 19 <u>84</u> , to <u>4/13</u> , 19 <u>86</u> . that (I) (we) last saw the deceased alive on <u>11/13</u> , 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					11/30, 1984			to		4/13, 1986								
22b. SIGNATURE <u>Doris Ya</u>					22c. DATE SIGNED <u>4/13/86</u>			DEGREE <u>MD</u>			ATTENDING PHYSICIAN		<input checked="" type="checkbox"/> DIRECTOR	<input type="checkbox"/> STAFF PHYSICIAN				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Don H. Yablonski</u>					22e. ADDRESS <u>10300 Greenbelt Rd. Seabrook, MD 20704</u>													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE			23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN			COUNTY		STATE					
Cremation		April 14'86			Westview Memorial Pk			Catonsville			Balto., Maryland							
24. FUNERAL DIRECTOR Harry H Witzke & Family Funeral Home Inc. 4112 Old Columbia Pike Ellicott City								25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE <u>Jutta Davidson-Mendes</u>							
								APR 17 1986										

2010-00

RECORDED BY
MOTOMURA

NO. 5

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked and Item 18 shows any injury, or other traumatic event, the medical examiner must be notified of same.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO. 2246		
1. FOR STATE REGISTRAR			2. DECEASED NAME (TYPE OR PRINT)			LAST			20. DATE OF DEATH MONTH DAY YEAR			26. HOUR		
			Edna HERDT						April 28, 1986			7:38 P.M.		
3. SEX Female			4. RACE White			5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY) 87			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE Pennsylvania			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's MD.					
10. CITY OR TOWN OF DEATH Lanham			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Doctors' Hospital of Pr. Geo. Co.			12a. USUAL OCCUPATION Homemaker			12b. KIND OF BUSINESS OR INDUSTRY Own Home					
13a. STATE Maryland			13b. COUNTY Pr Geo			13c. CITY OR TOWN Lanham			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE 9221 Fowler Lane 20801		
14. FATHER'S NAME Joseph			15. MOTHER'S MAIDEN NAME Katherine									16. ADDRESS Margaret Weber 9221 Fowler Lane, Lanham, MD.		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO. 162-50-6404			17. INFORMANT								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)			Cardio respiratory Arrest									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last			DUE TO, OR AS A CONSEQUENCE OF Acute myocardial infarction											
			DUE TO, OR AS A CONSEQUENCE OF Severe atherosclerotic occlusive vascular disease											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)														
① Acute pulmonary edema, ② Acute renal failure														
19a. DATE OF OPERATION 4/26/86			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Arterial Embolism (left arm)			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE								
22a. I certify that (I) (this hospital) attended the deceased from 4/25/86, 1986, to 4/28, 1986, that (I) (we) last saw the deceased alive on 4/28, 1986, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not view the body after death.												22c. DATE SIGNED 4/29/86		
22b. SIGNATURE 						DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) YADLA			22e. ADDRESS 7726 FINNIS LANE LANHAM MD 20706											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 5-5-86			23c. NAME OF CEMETERY OR CREMATORIAL Jefferson Mem Park			23d. LOCATION CITY OR TOWN Pleasant Hills, Penn. COUNTY STATE					
24. FUNERAL DIRECTOR NAME BeinHaner Mortuary 2630 W. Liberty Ave, Pittsburgh, Penn 15216									25a. DATE REC'D. BY REGISTRAR MAY 2 1986			25b. REGISTRAR'S SIGNATURE 		

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as a burial/transit permit. Then please remove carbon paper. Page 4 may be retained by the funeral director and should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 18 is marked or item 21 is marked, the deceased may have died from an injury, or other traumatic event. The medical examiner should be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH						8612247 REG. NO.								
1. FOR STATE REGISTRAR		1 DECEASED NAME [TYPE OR PRINT]		FIRST	MIDDLE	LAST	2a DATE OF DEATH	MONTH	DAY	YEAR	2b HOUR			
		FRED C HICKS					04	22	86	8 37 P.M.				
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR		IF UNDER 24 HRS					
Male		White		April 1, 1934		52 YRS	MONTHS	DAYS	HOURS	MIN.				
7a. BIRTHPLACE [STATE OR FOREIGN COUNTRY]		7b. CITIZEN OF WHAT COUNTRY?		8		MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGE'S COUNTY MD.							
Virginia		U.S.A.												
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY								
CHEVERLY		PGG HOSPITAL AND MEDICAL CENTER		Truck Driver		Giant Food								
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)						13c. CITY OR TOWN				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 3813 Cottage Terrace 20722			
13a. STATE Maryland		13b. COUNTY P.G.		Cottage City				13f. MOTHER'S MAIDEN NAME Emma		LAST Hensley				
14. FATHER'S NAME First		Middle		Last		15. MOTHER'S MAIDEN NAME First		Middle						
Floyd				Hicks		Emma								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		(YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT Mrs. S. Jean Hicks		ADDRESS		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 day				
Yes -Air Force Vietnam				406-42-4070										
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction														
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first (b)														
DUE TO, OR AS A CONSEQUENCE OF (c)														
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)														
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)								
21d. INJURY OCCURRED WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				21f. LOCATION STREET				CITY OR TOWN	COUNTY	STATE		
22a. I certify that (I) (this hospital) attended the deceased from 22 Apr 86 to 22 Apr 86, that (I) (we) lost the deceased alive on 22 Apr 86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.														
22b. SIGNATURE												DEGREE	22c. DATE SIGNED 4/23/86	
22d. PHYSICIAN'S NAME [TYPE OR PRINT] RICHARD H. HARRIS, M.D.						ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>						22e. ADDRESS P.G. General Hospital Cheverly MD		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS		23d. LOCATION CITY OR TOWN		CITY OR TOWN		COUNTY	STATE			
Burial		April 25, 1986 Md. Vet. Cemetery				Cheltenham		P.G.		Maryland				
24. FUNERAL DIRECTOR NAME F. Gasch's Sons F.H. P.A. Hyattsville, Maryland		ADDRESS		25a. DATE REC'D. BY REGISTRAR APR 24 1986		25b. REGISTRAR'S SIGNATURE L. L. Kishon Rendell								

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book stand moving about

CDU's cannot contain it

volume

or open book

CDU's

move about

X

bunching up in pockets

overhead desk in second floor

00-05683

DIVISION OF VITAL RECORDS, 201 W. PESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER AND TO THE FUNERAL DIRECTOR. PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS, AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

ITEM 1A STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 1 2 2 4 3	
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE KNOWN OF DEATH ESTI- MATED			MONTH DAY YEAR	2b. HOUR M 2d HOUR M	
KUM SUN NA					HILL	<input checked="" type="checkbox"/>			4 25 1986	7:30 AM	
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS	IF UNDER 1 YR. HOURS MIN.	IF UNDER 24 HRS.	2c. DATE PRONOUNCED DEAD			MONTH DAY YEAR	2d. HOUR M	
Female	Oriental	May 15 41	44 yrs.			<input checked="" type="checkbox"/>			4 25 1986	7:30 AM	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			
Korea		USA						Prince George's County MD.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY			
Suitland		3600 Diana Rd.			Cook			AAFB Mess			
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS			
Maryland		Pr George		Suitland				3600 Dianna Road 20746			
14. FATHER'S NAME FIRST		MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST		MIDDLE	LAST				
Sun		Nam	Na	Kum		Hui	Yi				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No			16b. SOCIAL SECURITY NO. 548-04-9969			17. INFORMANT James W Hill			ADDRESS Same as #13		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage</u> DUE TO, OR AS A CONSEQUENCE OF { Conditions, if any, which gave rise to immediate cause (a) stating the <u>under-</u> <u>lying cause last.</u> (b) DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY?			
								<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN	COUNTY	STATE	
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>										DATE SIGNED 4-25-86	
ACTUAL SIGNATURE		TITLE (SPECIFY) Assistant M.D. MEDICAL EXAMINER									
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS 111 Penn St., Balto., MD 21201									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE May 1, 1986			23c. NAME OF CEMETERY OR CREMATORIAL Washington National			23d. LOCATION CITY OR TOWN Suitland	CO PG	ST Md	
24. FUNERAL DIRECTOR NAME Robert E. Wilhelm		ADDRESS						25a. DATE REC'D. BY REGISTRAR MAY 05 1986			25b. REGISTRAR'S SIGNATURE John Davidson-Purcell
(VR A15 ME (5))											

1

00-04471

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be

executed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be signed for use at the burial/tranquillization permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is indicated or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												
REG. NO. 8012249												
1. DECEASED NAME (TYPE OR PRINT)			FIRST <i>VIOLET S.</i>		MIDDLE <i>S.</i>		LAST <i>Gill</i>		2a. DATE OF DEATH MONTH DAY YEAR		2b. HOUR 4 19 86 11.55am	
3. SEX Female			4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR January 2, 1928		6. AGE (IN YEARS LAST BIRTHDAY) 58 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia			7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGES COUNTY					
10. CITY OR TOWN OF DEATH CLINTON MD			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION SOUTHERN MARYLAND HOSPITAL		12a. USUAL OCCUPATION Beautician		12b. KIND OF BUSINESS OR INDUSTRY Watergate Salon					
13a. STATE Maryland			13b. COUNTY Prince George Ft. Washington		13c. CITY OR TOWN Prince George Ft. Washington		13d. INSIDE CITY LIMITS? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 8000 Murray Hill Dr. 20744			
14. FATHER'S NAME FIRST Eligah			MIDDLE E.		LAST Scruggs		15. MOTHER'S MAIDEN NAME FIRST Hattie		MIDDLE		LAST Vaughn	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 229-32-2774		17. INFORMANT Stephen N. Gill		ADDRESS 8000 Murray Hill Dr. Ft. Washington, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)			VENTRICULAR ASYSTOLE						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b)			DUE TO, OR AS A CONSEQUENCE OF (b) <i>Acute Anteroseptal Myocardial Infarction</i>									
			DUE TO, OR AS A CONSEQUENCE OF (c) <i>Coronary Artery Disease</i>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) DIABETES MELLUS.												
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE	
22a. I certify that (1) this hospital attended the deceased from Apr 19, 1986 to Apr 19, 1986 that (2) we last saw her deceased alive on Apr 19, 1986 and that in my (our) opinion death occurred on the date and hour and from the cause(s) stated (did not) view the body after death.												
22b. SIGNATURE <i>Terence Bertelle</i>			DEGREE <i>MD</i>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/>		MEDICAL DIRECTOR <input type="checkbox"/>		STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED Apr 23, 1986	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) TERENCE BERTELLE			22e. ADDRESS 7501 Surratts Rd. Clinton MD									
23a. BURIAL, CREMATION, REMOVAL (TYPE OR PRINT) Burial			23b. DATE 4/23/86		23c. NAME OF CEMETERY OR CREMATORIUM Ft. Lincoln Mausoleum		23d. LOCATION CITY OR TOWN Brentwood P.G. Maryland		COUNTY		STATE	
24. FUNERAL DIRECTOR NAME George P. Kalas Funeral Home			ADDRESS 6160 Oxon Hill Rd. Oxon Hill, Md.		25a. DATE REC'D. BY REGISTRAR APR 23 1986		25b. REGISTRAR'S SIGNATURE <i>Julia L. Dividens</i>					

3201.3 Visual Basic 6.0 Examples

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2000 million kWh will be supplied by wind power.

ANSWER: **ANSWER** **ANSWER** **ANSWER** **ANSWER** **ANSWER**

8000 1962-1963
1962-1963 8000 1962-1963

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been issued by the attending physician and completely filled in by the funeral director, page 1 and 2 should be detached for use as the burial permit. Then please remove carbon copies. Page 1 and 2 may be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 18 is marked "X" (any injury, or other traumatic event, the medical examiner may be called in).

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH														
REC. NO. 89 12250														
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2d. DATE OF DEATH MONTH DAY YEAR			2d. HOUR					
REVA M. HISSEM						4/23/86			750 P.M.					
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			# UNDER 1 YEAR				
FEMALE		WHITE		AUG. 20, 1902			83 yrs.			# UNDER 24 HRS.				
7a. BIRTHPLACE COUNTRY		7b. CITIZEN OF WHAT COUNTRY?		MARRIED <input type="checkbox"/> NEVER-MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			7c. BALTIMORE CITY OR COUNTY OF DEATH			7d. PRINCE GEORGES CO.				
W. VA.		U.S.A.												
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCY BEFORE ADMISSION)			12b. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12c. KIND OF BUSINESS OR INDUSTRY				
ADELPHI		PRESIDENTIAL WOODS NURSING HOME		Md. P.G.C. BOWIE			HOMEMAKER			AT HOME				
13a. STATE		13b. COUNTY		13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE 3909 NEW HAVEN CT. #B8 20716				
Md.		P.G.C.		BOWIE										
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST												
CALVIN MATHINEY		UNKNOWN												
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (IF YES, OR UNKNOWN) NO		16b. SOCIAL SECURITY NO ----		17. INFORMANT BETTY M. BARRETT			18. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			ADDRESS (SAME AS ITEM #13)				
		235-34-5335												
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Sepsis</i>														
DUE TO, OR AS A CONSEQUENCE OF (b) <i>Pneumonia</i>														
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last														
DUE TO, OR AS A CONSEQUENCE OF (c)														
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a <i>Organic Brain Syndrome</i>														
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED ENTER NATURE OF INJURY IN ITEM 1b (PART I OR PART II)									
22a. THE INJURY OCCURRED AT HOME <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22b. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			22c. LOCATION STREET CITY OR TOWN COUNTY STATE									
23a. I certify that (i) this hospital attended the deceased from <i>4/23 1986</i> to <i>4/23 1986</i> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (ii) we did not view the body after death.														
23b. SIGNATURE <i>Stuart Turkevitz MD</i>														
23c. DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>														
23d. DATE SIGNED <i>4/24/86</i>														
24a. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Stuart Turkevitz</i>		24b. ADDRESS OAO Bldg #430, 2500 Greenway Ctr., Dr., Greenbelt, Md.												
25a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		25b. DATE 4-28-1986			25c. NAME OF CEMETERY OR CREMATORIUM CULPEPER NAT'L CEM.			25d. LOCATION CITY OR TOWN COUNTY STATE CULPEPER CULPEPER CO. Va.			25e. DATE REC'D. BY REGISTRAR APR 29 1986		25f. REGISTRAR'S SIGNATURE <i>Jane D. Chambers</i>	
BP_____		ADDRESS RIVERDALE, Md. 20737												
DHMH - 16 60M 7/84 (VRA 15. 4)														

BT070

RECORDED IN 1974

BY THE SOUTHERN CALIFORNIA RECORDING COMPANY

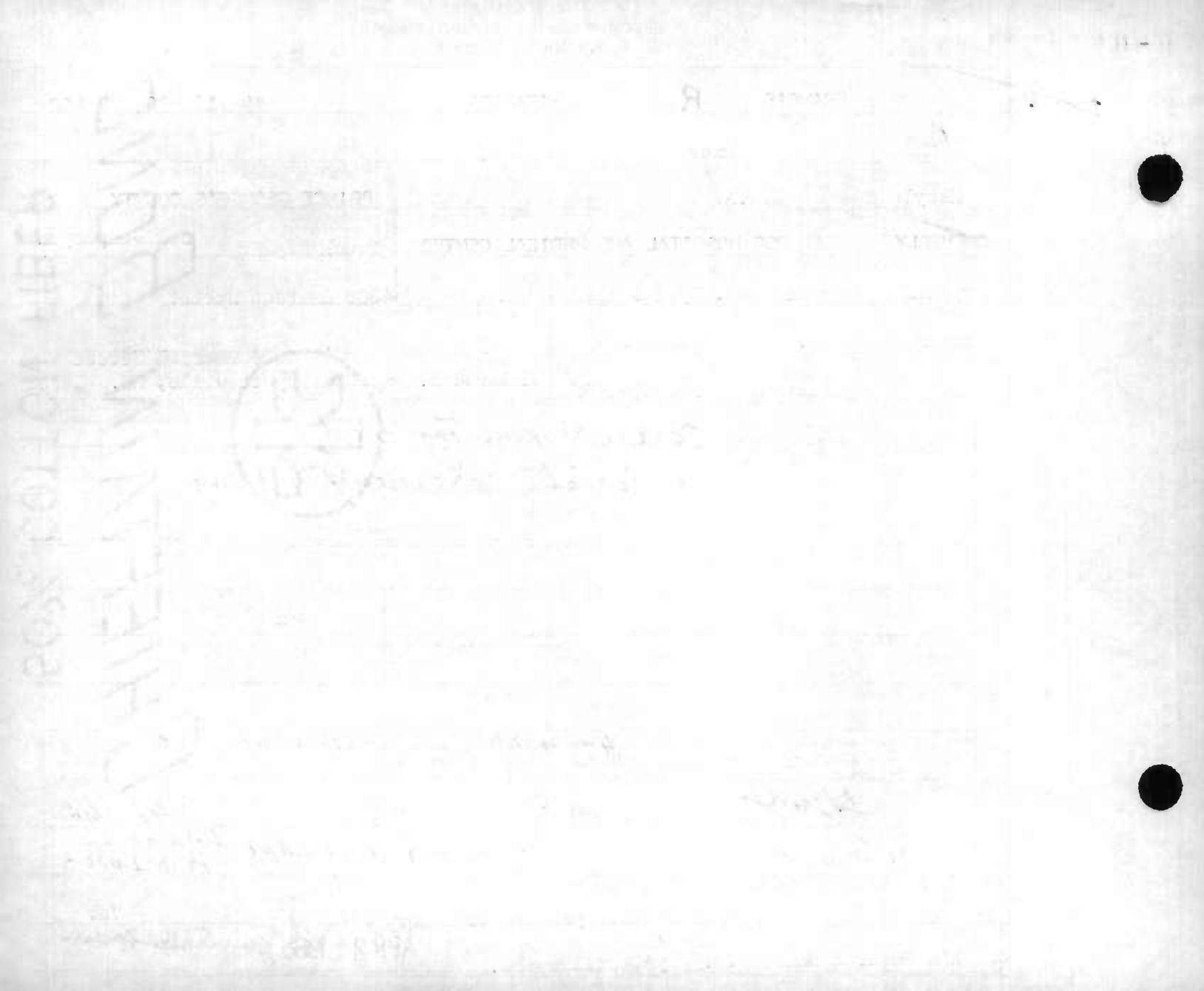
RECORDED IN 1974

(SOUTHERN CALIFORNIA) RECORDING COMPANY

10. HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filled in by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, then please return this form to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If Item 21 is marked "No," show any injury, or other traumatic event, medical condition, or disease which caused the death.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO. 12251					
1. DECEASED NAME (TYPE OR PRINT)			FIRST			MIDDLE			LAST			2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR	
FRANCIS R.									HITAFFER			04	16	86		8 45PM	
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			7. IF UNDER 1 YEAR			8. IF UNDER 24 HRS				
Male		White		MONTH DAY YEAR			70 YRS			MONTHS DAYS			HOURS MIN.				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			PRINCE GEORGE'S COUNTY MD.							
Maryland		U.S.A.		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>													
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)										12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY		
CHEVERLY		PGG HOSPITAL AND MEDICAL CENTER										Truck Repair			Self-employed		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)												13e. STREET ADDRESS / ZIP CODE					
13a. STATE		13b. COUNTY		13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?			13e. STREET ADDRESS / ZIP CODE							
Maryland		Prince Geo.		Hyattsville			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			4600 Emerson Street 20781							
14. FATHER'S NAME		FIRST		MIDDLE			15. MOTHER'S MAIDEN NAME			FIRST			MIDDLE				
Francis		M.		Hitaffer			Mary			C.			Saker				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES OR NO OR UNKNOWN)		(IF YES GIVE WAR OR DATES)		16b. SOCIAL SECURITY NO.			17. INFORMANT			18. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
Yes		peacetime		579-07-2485			Mildred D. Hitaffer			4600 Emerson Street			Hyattsville, Md. 20781				
III. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY																	
IMMEDIATE CAUSE (a) <i>Cardio Respiratory Arrest</i>																	
DUE TO, OR AS A CONSEQUENCE OF (b) <i>rulesthetic carcinoma lung</i>																	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last																	
DUE TO, OR AS A CONSEQUENCE OF (c) _____																	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED										20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
												YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)													
		P.M. 19															
21d. INJURY OCCURRED <small>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/></small>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET			CITY OR TOWN			COUNTY		STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>4-14-86</u> , 19 <u>86</u> , to <u>4-16</u> , 19 <u>86</u> , that (I) (we) last saw the deceased alive on <u>4-16</u> , 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death																	
22b. SIGNATURE <i>Hyatt</i>		22c. DEGREE <i>M.D.</i>										22d. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22e. DATE SIGNED <i>4/12/86</i>			
22f. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Y ADA</i>		22g. ADDRESS <i>7726 FINN LANE LANHAM MD 20706</i>															
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN			COUNTY		STATE					
Cremation		4/19/86		Metropolitan Crematory Alexandria			ALEXANDRIA			VA.							
24. FUNERAL DIRECTOR NAME		ADDRESS										25. DATED REC'D. BY REGISTRAR'S OFFICE APR 21 1986 <i>Jane Davidson-Purcell</i>					
Gasch's Funeral Home, P.A.		Hyattsville, Md.															



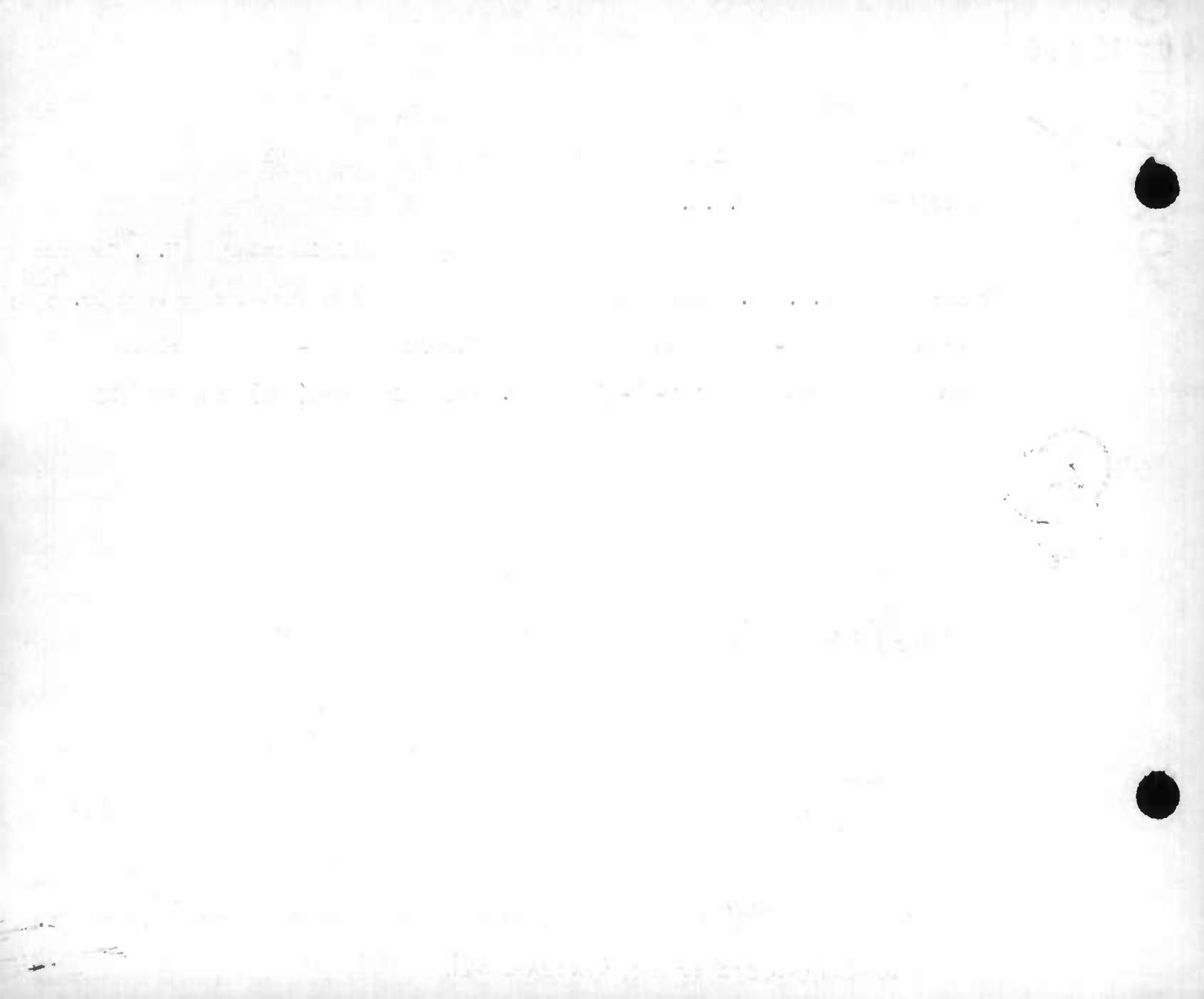
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be detached for view as the burial permit. Then please remove column 1 and 2 should be filled with item 77. Your permit with the State Dept. of Health and Mental Hygiene prior to burial, cremation or other disposition.

IMPORTANT: If item 18 is marked or item 18 shows any injury, or other traumatic or non-traumatic cause of death, attach a separate sheet of paper and describe the cause of death in detail.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 6 1 2 2 5 2									
										REG. NO.									
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST			2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR					
Helen Elizabeth HITCHCOCK								April 5, 1986						8:33 a.m.					
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS							
Female		White		Month June Day 20; Year 1894			91 YRS.			MONTHS	DAYS	HOURS	MIN.						
7a. BIRTHPLACE COUNTRY		7b. CITIZEN OF WHAT COUNTRY?		8.			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.									
Delaware		U.S.A.		MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>			Prince George's County,												
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)								12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY							
Lanham		AM/Doctors Hospital of P.G. County								Administrator		U.S. Government							
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)										13e. STREET ADDRESS / ZIP CODE									
13a. STATE		13b. COUNTY		13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?			#616									
Maryland		P.G. Co.		College Park			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			6200 Westchester Park Dr. 20740									
14. FATHER'S NAME		MIDDLE		LAST			15. MOTHER'S MAIDEN NAME			MIDDLE		LAST							
FIRST James		-		Scott			FIRST Abigail			-		Walter							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT			ADDRESS			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
No		None		212-14-1557			Mr. Donald Hitchcock (son) Same as # 13												
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)										Sept: clニア									
887 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost										DUE TO, OR AS A CONSEQUENCE OF (b)									
										DUE TO, OR AS A CONSEQUENCE OF (c)									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a:										Fracture left hip.									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED								20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?							
2/11/85		Fracture left hip Gastric stomy for Prolonging								YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)			P.M.		P.M.		19								
21d. INJURY OCCURRED <input type="checkbox"/> WHILE AT WORK <input type="checkbox"/> NEAR WHILE AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION			STREET		CITY OR TOWN		COUNTY		STATE						
22a. I certify that (I) (this hospital) attended the deceased from 2-6-85 to 4-4-85, that (I) (we) lost saw the deceased alive on 4-4-1985, and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										22b. SIGNATURE K. S. MATTHEW				DEGREE MD		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 4/5/85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)										22e. ADDRESS 6510 Kinnelwood Ave. Riverdale, Md 20737									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION		CITY OR TOWN		COUNTY		STATE						
Burial		4/8/86		Old Kennett Cemetery			Kennett Square Chester Pa.												
24 FUNERAL DIRECTOR NAME W.W. Chambers co. inc. Riverdale Md.										25a. DATE REC'D. BY REGISTRAR APR 10 1986		25b. REGISTRAR'S SIGNATURE							



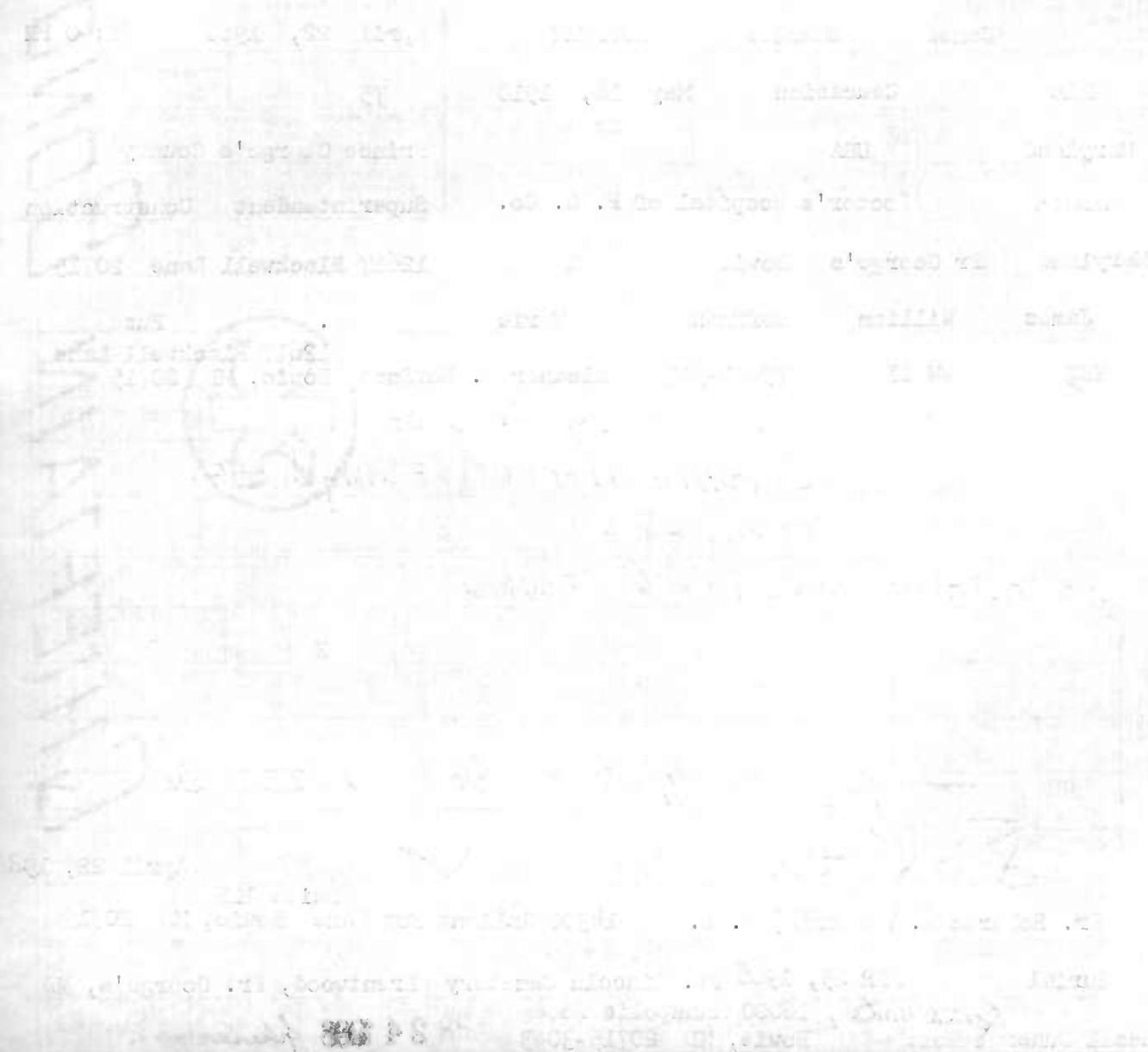
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in full by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be held within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or if item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8 9 REG. NO. 1 2 2 5 3							
1 - STATE REGISTRAR			1. DECEASED NAME (TYPE OR PRINT)			MIDDLE			LAST			20. DATE OF DEATH	MONTH	DAY	YEAR	2b HOUR			
			James Charles						HOFFMAN			April 22, 1986				1:00 PM			
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS					
Male			Caucasian			MONTH DAY YEAR			75 YRS			MONTHS DAYS		HOURS MIN.					
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b CITIZEN OF WHAT COUNTRY?			8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH										
Maryland			USA			WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			Prince George's County MD.										
10 CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)									12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b KIND OF BUSINESS OR INDUSTRY				
Lanham			Doctor's Hospital of P. G. Co.									Superintendent			Construction				
13a STATE			13b COUNTY			13c CITY OR TOWN			13d INSIDE CITY LIMITS?			13e STREET ADDRESS / ZIP CODE							
Maryland			Pr George's			Bowie			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			12617 Blackwell Lane 20715							
14 FATHER'S NAME			FIRST MIDDLE LAST			15 MOTHER'S MAIDEN NAME													
James William Hoffman						Marie A. Fuse													
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES			16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WW II			17 INFORMANT			ADDRESS			12617 Blackwell Lane Bowie, MD 20715							
18 CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c.) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)			RESPPIRATORY FAILURE												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			DUE TO, OR AS A CONSEQUENCE OF (b) CHRONIC OBSTRUCTIVE LUNG DISEASE.																
			DUE TO, OR AS A CONSEQUENCE OF (c) ENPHYSMA.																
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) METASTATIC CARCINOMA OF LUNG.																			
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?										
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)													
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY	STATE						
22a I certify that (I) (this hospital) attended the deceased from 4/17/86, 19, to 4/22, 19, that (I) (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (they) did not view the body after death.																			
22b. SIGNATURE			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED			April 22, 1986							
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS			Suite 122			14300 Gallant Fox Lane Bowie, MD 20715										
Dr. Roberto A. DePetris, M. D.																			
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE APR 25, 1986			23c. NAME OF CEMETERY OR CREMATORIAL Ft. Lincoln Cemetery			23d. LOCATION CITY OR TOWN Brentwood, Pr. George's, MD										
24 FUNERAL DIRECTOR NAME Beall Funeral Home			ADDRESS 16000 Annapolis Road Bowie, MD 20715-3043			25a. DATE RECD. BY REGISTRAR APR 24 1986			25b. REGISTRAR'S SIGNATURE Julia Leidson-Randall										

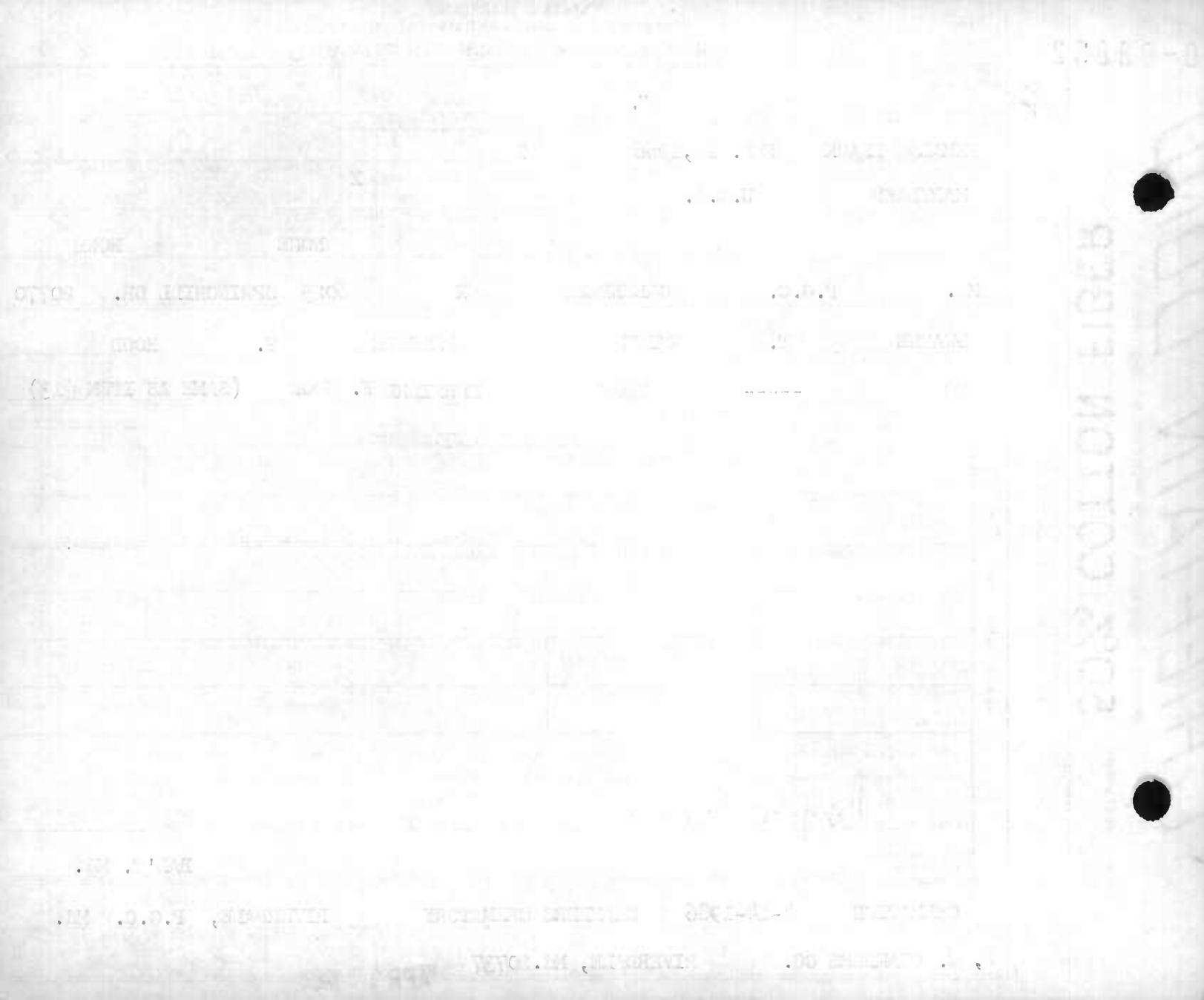
20210400



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES.

TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO. 2254			
1- FOR STATE REGISTRAR			1. DECLARED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE KNOWN OF ESTI- DEATH MATED			MONTH DAY YEAR 4-11-86 19 M			
			SHAVONNE K. HOOD						<input checked="" type="checkbox"/> 4-11-86 19 M						
3. SEX FEMALE		4. RACE BLACK		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS) LAST BIRTHDAY		IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		2c. DATE PRONOUNCED DEAD			
				FEB. 16, 1986				YRS. 1				4-11-86 19 7:20PM			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED		9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's County									
10. CITY OR TOWN OF DEATH Lanham			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Doctor's Hospital			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) NONE			12b. KIND OF BUSINESS OR INDUSTRY NONE						
13a. STATE Md.		13b. COUNTY P.G.C.		13c. CITY OR TOWN GREENBELT		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 6025 SPRINGHILL DR. 20770							
14. FATHER'S NAME FIRST DWAYNE			MIDDLE T.			LAST SMITH			15. MOTHER'S MAIDEN NAME FIRST DERNIERE			MIDDLE F.		LAST HOOD	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO			16b. SOCIAL SECURITY NO. -----			17. INFORMANT DERNIERE F. HOOD			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Sudden infant death syndrome DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).															
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20 AUTOPSY?									
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART 1 OR PART 2)			<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>															
ACTUAL SIGNATURE <i>Margarita A. Korell</i> TITLE (SPECIFY) M.D. Assistant MEDICAL EXAMINER															
EXAMINER'S NAME (TYPE OR PRINT) Margarita A. Korell, M.D.			ADDRESS 111 PennStreet			DATE SIGNED 4-12-86									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION			23b. DATE 4-14-1986			23c. NAME OF CEMETERY OR CREMATORIAL CHAMBERS CREMATORY			23d. LOCATION CITY OR TOWN RIVERDALE, P.G.C. Md.						
24. FUNERAL DIRECTOR NAME W. W. CHAMBERS CO.			ADDRESS RIVERDALE, Md. 20737			25a. DATE REC'D. BY REGISTRAR APR 17 1986			25b. REGISTRAR'S SIGNATURE <i>Richard Rendall</i>						
DHMH - 17 (VR A15 ME (5))															



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 12255

00-05074
 TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORMS 1 AND 2. RETAIN PAGE 5 FOR YOUR FILES.
 TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE KEPT WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

1-
STATE
REGISTRAR

X DECEASED NAME (TYPE OR PRINT)			FIRST <i>Howard</i>	MIDDLE <i>Pierce</i>	LAST <i>Horton</i>	2a DATE KNOWN OF ESTI- MATED DEATH MONTH DAY YEAR <i>4-26 1986</i>	2b HOUR M M <i>8:30 AM</i>	
3 SEX <i>Male</i>	4 RACE <i>White</i>	5. DATE OF BIRTH MONTH DAY YEAR <i>5-17-1908</i>	6. AGE (IN YEARS LAST BIRTHDAY) 77 yrs.	7f. CITIZEN OF WHAT COUNTRY? <i>USA</i>	7b. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED WIDOWED <input type="checkbox"/> DIVORCED	2c. DATE PRONOUNCED DEAD <i>4-26 1986</i>	2d. HOUR M M <i>8:30 AM</i>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Virginia</i>			7c. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT A SUCH FACILITY, GIVE STREET ADDRESS) <i>Doctors' Hospital</i>			9 BALTIMORE CITY OR COUNTY OF DEATH <i>Prince George's</i>		
10. CITY OR TOWN OF DEATH <i>Lanham</i>			11a. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <i>Maryland</i>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Field Manager</i>		
13b. COUNTY <i>P.G.</i>			13c. CITY OR TOWN <i>College Park</i>			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS Rd. <i>5917 Bryn Mawr, 20740</i>	
14. FATHER'S NAME FIRST <i>Lonnie</i>			15. MOTHER'S MAIDEN NAME FIRST <i>Gertrude</i>			16. KIND OF BUSINESS OR INDUSTRY <i>Insurance</i>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <i>Yes</i>			16b. SOCIAL SECURITY NO. <i>578-03-8017</i>			17. INFORMANT ADDRESS <i>Anna L. Horton, Wife, Same as #13</i>		
18. CAUSE OF DEATH (Enter only one cause in line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Diabetic cerebral vascular accident</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH								
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?					20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN	COUNTY	STATE
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>								
ACTUAL SIGNATURE <i>Augusto P. Rodriguez, M.D.</i>		TITLE (SPECIFY) <i>Deputy</i>		MEDICAL EXAMINER				
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS <i>5009 Rayburn Ct, Temple Hills, MD</i>		DATE SIGNED <i>4-26-86</i>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE <i>Burial 4-30-1986</i>		23c. NAME OF CEMETERY OR CREMATORIAL <i>Ft. Lincoln Cem.</i>		23d. LOCATION CITY OR TOWN <i>Brentwood, P.G., Maryland</i>		
24. FUNERAL DIRECTOR NAME <i>Francis Gasch's Sons, P.A.</i>		ADDRESS <i>4739 Balto., Ave., Hyattsville, Md.</i>		25a. DATE REC'D. BY REGISTRAR <i>APR 29 1986</i>		25b. REGISTRAR'S SIGNATURE <i>J. Schaeffer</i>		

00-05690

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REO. NO.

12256

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician (and completed in by the funeral director), page 3 should be detached for use as the burial-tombstone permit. Then please return certificate pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT:

MEDICAL CERTIFICATION

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a DATE OF DEATH	MONTH	DAY	YEAR	2b HOUR			
Ollie I Huffman						April 29, 1986				10:20P _M			
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)				IF UNDER 1 YEAR			
Female		black		Sept 5 1950		36				MONTHS DAYS			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8		MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH			
Mississippi		USA								Prince Georges County			
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY					
Laurel		Greater Laurel Beltsville Hospital		machine operator				Plastic co					
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)						13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
13a. STATE Maryland		13b. COUNTY Prince George		13c. CITY OR TOWN Laurel		13e. STREET ADDRESS / ZIP CODE 11698 S. Laurel Dr. 20708							
14. FATHER'S NAME FIRST Emmet		MIDDLE		LAST Huffman		15. MOTHER'S MAIDEN NAME FIRST Jessie		MIDDLE May		LAST Kyles			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES OR NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. 1969-1971		17. INFORMANT Jessie Fletcher 229 Tipton St 39090		ADDRESS Kosciusko, Mississippi		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)						Generalized carcinomatosis							
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						(b) Primary carcinoma Right Breast							
DUE TO, OR AS A CONSEQUENCE OF (c)													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?					
						YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE			
22a. I certify that (I) (this hospital) attended the deceased from 4/22/86, 19, to 4/29/86, 19, that (I) (we) last saw the deceased alive on 4/29/86, 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE <i>Donaldson Funeral Home P.A.</i>		22c. DEGREE M.D.		22d. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22e. DATE SIGNED 4/30/86							
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DR TAPY MOURTZANAKIS		22e. ADDRESS 3450 Fort Meade Rd, Suite 109, Laurel											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) burial		23b. DATE May 3, 1986		23c. NAME OF CEMETERY OR CREMATORIAL City Cemetery		23d. LOCATION CITY OR TOWN Kosciusko		COUNTY		STATE Mississippi			
24. FUNERAL DIRECTOR NAME Donaldson Funeral Home P.A.		ADDRESS Laurel, Maryland		25a. DATE OF BY RELEASER MAY 05 1986		25b. REGISTRATION NUMBER John D. Donaldson							

①



00-06040

DIVISION OF VITAL RECORDS, 201 W. BALTIMORE ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE WRITING THE WORD "PENDING" IN PENCIL. ITEM 1B, RETAIN PAGE 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM RM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. BALTIMORE STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR BURIAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO. 2257			
1- FOR STATE REGISTRAR															
1. DECEASED NAME (TYPE OR PRINT)		FIRST			MIDDLE			LAST			2a DATE KNOWN OF ESTI- DEATH MATED	MONTH	DAY	YEAR	2b HOUR
MILDRED		MAE			HUMPHREY						<input type="checkbox"/>	Apr 29	1986		M
3 SEX	4 RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YR.		IF UNDER 24 HRS					2c DATE PRONOUNCED DEAD	MONTH	DAY	YEAR	2d HOUR 8:15 a.m.
Female	Negro	April 18, 1914	72 yrs.	MONTHS	DAYS	HOURS	MIN.				Apr 29	1986			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?			8			MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH				
Alabama		U. S. A.									Prince Georges				
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY							
Oxon Hill		2113 Alice Ave. Apt 4			Domestic						Private Ind.				
13a. STATE Maryland		13b. COUNTY Prince Georges		13c. CITY OR TOWN Oxon Hill		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 2113 Alice Avenue #4		201 W. BALTIMORE ST.					
14. FATHER'S NAME FIRST J. Dallas Britt		MIDDLE		LAST		15. MOTHER'S MAIDEN NAME FIRST Hattie Boykin									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		16c. INFORMANT Clifford Humphrey, Husband, Oxon Hill, Md.		ADDRESS 2113 Alice Ave. #4									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cancer of the colon</u> DUE TO, OR AS A CONSEQUENCE OF												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause lost. (b) DUE TO, OR AS A CONSEQUENCE OF (c)															
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (o) <u>Diabetes mellitus</u>															
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY?							
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART 1 OR PART 2)			<input type="checkbox"/> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY	STATE			
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> TITLE (SPECIFY) EXAMINER'S NAME (TYPE OR PRINT) <u>Augusto P. Rodriguez, M.D.</u> M.D. Deputy MEDICAL EXAMINER												Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion			
EXAMINER'S NAME (TYPE OR PRINT) <u>Augusto P. Rodriguez, M.D.</u> ADDRESS <u>5009 Rayburn Ct, Temple Hills, MD</u>												DATE SIGNED <u>4/29/86</u>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE 3 May 86		23c. NAME OF CEMETERY OR CREMATORIAL Lincoln Memorial Cem.			23d. LOCATION CITY OR TOWN Suitland, P. G. Co., Maryland		COUNTY		STATE				
BURIAL															
24. FUNERAL DIRECTOR NAME W. ERNEST JARVIS CO., INC.		ADDRESS 1432 14th St., NW Washington, D. C.			25a. DATE REC'D. BY REGISTRAR MAY 07 1986		25b. REGISTRAR'S SIGNATURE <u>John L. Anderson, Jr.</u>								
BP															
DHMH - 17 (VR A15 ME (5))															

01070-1



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be detached for use as the burial/transit permit. Then please remove carbapapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 18 shows any injury, or other traumatic event, the medical

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
RE. NO. 12258											
1 - FOR STATE REGISTRAR			1 DECEASED NAME FIRST ANNA M. Huppmann			2a. DATE OF DEATH 04-25-86			2b. HOUR 7 30AM M		
3. SEX Female			4. RACE Caucasian			5. DATE OF BIRTH MONTH Feb. DAY 14, YEAR 1892			6. AGE (IN YEARS LAST BIRTHDAY) 94 YRS		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington, D.C.			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGE'S MD.		
10. CITY OR TOWN OF DEATH CHEVERLY			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION PRINCE GEORGE'S GENERAL HOSPITAL			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker			12b. KIND OF BUSINESS OR INDUSTRY Own Home		
13a. STATE Maryland			13b. COUNTY Prince Geo.			13c. CITY OR TOWN Avondale			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME Christian			15. MOTHER'S MAIDEN NAME Sadie			11a. STREET ADDRESS / ZIP CODE 2004 Wardman Rd. 20782					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. 579-68-2216			17. INFORMANT Sally Hopper, Avondale, Maryland 20782			2004 Wardman Road		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute myocardial infarction</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) <u>Congestive heart failure</u> days (c) <u>Atherosclerotic heart disease</u> years											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
MEDICAL CERTIFICATION		19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT HOME <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE	
22a. I certify that (I, this hospital) attended the deceased from April 20, 1986, to April 25, 1986, during (we) last saw the deceased alive on April 24, 1986, and that (my) (our) opinion death occurred on the date and hour and from the causes stated above.											
22b. SIGNATURE <u>John L. Stuckwitz</u> DEGREE MD ATTENDING MEDICAL STAFF PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/> DATE SIGNED <u>4/25/86</u>											
22c. PHYSICIAN'S NAME (TYPE OR PRINT) <u>P SCHISSLER MD</u> ADDRESS <u>7500 Greenway Ctr. or Greenbelt Rd. 20770</u>											
23a. BURIAL, CREMATION, REMOVAL SPECIFIED Burial			23b. DATE 4-28-1986			23c. NAME OF CEMETERY OR CREMATORIALy St. Mary's Cemetery Washington, D.C.			23d. LOCATION CITY OR TOWN		
24. FUNERAL DIRECTOR Francis Gasch's Sons, P.A. 4739 Baltimore Ave., Hyattsville, Md.			ADDRESS			25a. DATE REC'D. BY REGISTRAR APR 29 1986			25b. REGISTRAR'S SIGNATURE <u>Jane Davidson-Schissler</u>		

15030-00

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10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use in the burial permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on Item 18 show any injury, or other traumatic event, the medical examiner must be notified once.

MEDICAL CERTIFICATION

1. DECEASED NAME				FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR			
10. DECEASED NAME				William	Henry	Hutchings	April 12, 1986				2:30 a.m.			
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS			
Male		White		Month March Day 6, Year 1929			57		MONTHS DAYS		HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH							
Pennsylvania		U.S.A.					Prince George's County MD.							
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY							
Riverdale		5717 66th Avenue		20737			Representative		PEPCO					
13a. STATE				13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS / ZIP CODE				
Maryland				P.G. Co.		Riverdale		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		5717 66th Avenue / 20737				
14. FATHER'S NAME		FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME			FIRST	MIDDLE	LAST	ADDRESS			
William		John		Hutchings	Anna			Anna	Louise	Hoffman				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT			18. CAUSE OF DEATH (Enter only one cause per line for Part I, II, and III.) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>cardiovascular failure</i> DUE TO, OR AS A CONSEQUENCE OF <i>mitral valve disease</i>							
No		None		192-20-8561			DUE TO, OR AS A CONSEQUENCE OF <i>mitral valve disease</i>							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>anemia, chronic bronchitis, hypertension</i>														
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			19c. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?							
					YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN	COUNTY	STATE				
22a. I certify that (I) (the hospital) attended the deceased from <u>4/11/86</u> , to <u>1986</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated saw the deceased alive on <u>4/11/86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (We did not view the body after death.)														
22b. SIGNATURE <i>Lewis H. Dennis</i> <i>M.D.</i>														
22c. DATE SIGNED <u>4/11/86</u>		22d. PHYSICIAN'S NAME (TYPE OR PRINT)			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22e. ADDRESS <i>831 University Blvd. E. Silver Spring, Md.</i>						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Cremation</i>		23b. DATE <u>4-14-1986</u>		23c. NAME OF CEMETERY OR CREMATORIAL <i>Chambers Crematory</i>			23d. LOCATION CITY OR TOWN <i>Riverdale, P.G. Co., Maryland</i>		23e. DATE RECEIVED BY REGISTRAR <u>APR 17 1986</u>					
24. FUNERAL DIRECTOR NAME <i>Chambers Funeral Home</i>		ADDRESS <i>Riverdale, Maryland</i>			25a. REGISTRAR'S SIGNATURE <i>APR 17 1986</i>									

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

3012260

10. HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 shall be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked as Item 18 showing an injury, or other traumatic event, the medical

1. FOR STATE REGISTRAR		2a. DATE OF DEATH MONTH DAY YEAR										2b. HOUR				
1. DECEASED NAME (TYPE OR PRINT)		FIRST			MIDDLE		LAST			4 11 86			12:35 AM			
3. SEX		4. RACE			5. DATE OF BIRTH MONTH 12 DAY 2 YEAR 1918		6. AGE (IN YEARS LAST BIRTHDAY) 67			7. IF UNDER 1 YEAR MONTHS 0 DAYS 0		8. IF UNDER 24 HRS HOURS 12 MIN. 35				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington, D.C.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGES MD.								
10. CITY OR TOWN OF DEATH CLINTON		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Southern Md Hospital			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Contract Spec.			12b. KIND OF BUSINESS OR INDUSTRY Naval Air Syst.								
13a. STATE Md.		13b. COUNTY P.G.		13c. CITY OR TOWN Forestville		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 2801 Lakehurst Ave. 20747								
14. FATHER'S NAME FIRST William		MIDDLE E.		LAST Jackson		15. MOTHER'S MAIDEN NAME FIRST Agnes		MIDDLE M.		LAST Casby						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. W.W. II 578-05-3331		17. INFORMANT Margaret T. Jackson as in item 13		ADDRESS			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		CARDIORESPIRATORY ARREST														
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		{ (b) METASTATIC CARCINOMA														
{ (c) COLON CARCINOMA -																
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																
CORONARY ARTERY DISEASE																
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY		STATE				
22a. I certify that (I) (this hospital) attended the deceased from 4-1-86 to 4-10-86, that (I) (we) last saw the deceased alive on 4-10-86 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																
22b. SIGNATURE <i>Raj. Samtanji</i>		22c. DEGREE MD.			22d. ATTENDING PHYSICIAN <input checked="" type="checkbox"/>		MEDICAL DIRECTOR <input type="checkbox"/>		STAFF PHYSICIAN <input type="checkbox"/>		22e. DATE SIGNED 4-11-86					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Raj. Samtanji		22e. ADDRESS 8926 Woodward Rd, Clinton, Md.														
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 4-14-86			23c. NAME OF CEMETERY OR CREMATORIAL Resurrection Cem.			23d. LOCATION CITY OR TOWN Clinton			23e. COUNTY P.G.		STATE Md.			
24. FUNERAL DIRECTOR NAME G.P. Kalas F.H. 6160 Oxon Hill Rd. Oxon Hill, Md.		25a. ADDRESS 			25b. DATE REC'D. BY REGISTRAR APR 14 1986			25c. REGISTRAR'S SIGNATURE <i>John F. Smith</i>								

FC BTR S ST
X
.A.R.U .O.I metacides

level Goutxot see

F100 level temperature 108
X Efficiency .O.I .6M
Graph X zero 100% .A. missing
18 min as constant .P. temperature 108-10-333 IT .W. see

.6M .O.I metacides Goutxot
Goutxot see HILL Rd. Cox Hill Rd.
G.H. Kite E. etc Cox Hill Rd. Cox Hill Rd.

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PAGE 3. RETAIN PAGE 5 FOR YOUR FILES.

TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1, 2, AND 3 SHOULD BE FILLED, WITHIN 72 HOURS, AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO. 12261					
1. DECEASED NAME (TYPE OR PRINT)				FIRST MIDDLE LAST				2a. DATE KNOWN OF ESTI- MATED				2b. HOUR					
KANTILAL CHANDMALJI JAIN								<input type="checkbox"/> MONTH DAY YEAR 4-3 1986				M					
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YR.		IF UNDER 24 HRS		7c. DATE PRONONCED DEAD		2d. HOUR			
male		Indian		Dec. 7 1943		42 yrs.		MONTH DAYS		HOURS MIN		APRIL 3 1986		A 1:18			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8.		9. BALTIMORE CITY OR COUNTY OF DEATH		MD.									
India		U.S.A.		MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		Prince George's											
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY											
Lanham		Doctors' Hospital of Pr. Geo. Co. Professor		Professor		Teaching		20716									
13a. STATE Md.		13b. COUNTY P.G.		13c. CITY OR TOWN Mitchellville		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 3417 Inverwood Lane									
14. FATHER'S NAME FIRST		MIDDLE		LAST		15. MOTHER'S MAIDEN NAME FIRST		MIDDLE		LAST							
Chandmalji				Jain		Bhuribai				Jain							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO. no -----		16c. ADDRESS Highland Md.		17. INFORMANT Pankaji Desai		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Hypertensive cardiovascular disease</i>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last.				DUE TO, OR AS A CONSEQUENCE OF													
				(b) DUE TO, OR AS A CONSEQUENCE OF													
				(c)													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)																	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?													
				<input type="checkbox"/> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>													
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)													
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE							
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																	
ACTUAL SIGNATURE <i>Augusto F. Rodriguez</i>				TITLE (SPECIFY) Deputy M.D.		MEDICAL EXAMINER											
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS 5009 Rayburn Ct, Temple Hills, Md		DATE SIGNED 4-3-86													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 4/5/86		23c. NAME OF CEMETERY OR CREMATORY Balto. Wash. Crematory		23d. LOCATION CITY OR TOWN Laurel		COUNTY		STATE							
24. FUNERAL DIRECTOR NAME FLECK F.H. INC.		ADDRESS 7601 SANDY SPRING Rd. Laurel, Md. 20707		25a. DATE REC'D. BY REGISTRAR APR 01 1986		25b. REGISTRAR'S SIGNATURE <i>John F. Fleck</i>											
BP _____																	
DHMH - 17 (VR A15 ME (5))																	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be reattached to the burial-formal permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal of remains.

IMPORTANT: If item 21 is marked or Item 28 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					8012262		
					REG. NO.		
1. DECEASED NAME (TYPE OR PRINT)	FIRST MIDDLE LAST			2a. DATE OF DEATH	MONTH DAY YEAR	2b. HOUR	
HENRY (N.M.I.) JAMES				04 10 86		9:15 Pm	
3. SEX	4. RACE	5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)	7. IF UNDER 1 YEAR	
Male	White	MONTH Dec. 25, 1889 DAY YEAR			96	MONTHS DAYS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
Italy	U.S.A.			9. BALTIMORE CITY OR COUNTY OF DEATH			
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			
Clinton	Southern Md Hospital			Retired Waiter			
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE	
Maryland	P.G.	Hyattsville				6926 Greenvale Parkway 20784	
14. FATHER'S NAME FIRST MIDDLE LAST	15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST						
Unknown	Unknown						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) _____	APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
No	578-07-6273	Rosemary K. Baxter	3104 B. Park Drive Rome, N.Y. 13440				
DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last							
DUE TO, OR AS A CONSEQUENCE OF (c) _____ Atherosclerotic Heart Disease							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Inconclusive							
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET	CITY OR TOWN	COUNTY	STATE		
22a. I certify that (I) (this hospital) attended the deceased from 4-14-86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>M. Mostaan</i>	DEGREE	ATTENDING PHYSICIAN <input checked="" type="checkbox"/>	MEDICAL DIRECTOR <input type="checkbox"/>	STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED 4-11-86		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) M. MOSTAAN M.D.	22e. ADDRESS 4235 28th Ave Temple Hills, Md.						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE Burial	23c. NAME OF CEMETERY OR CREMATORIAL Ft. Lincoln Cem.	23d. LOCATION CITY OR TOWN Brentwood	23e. COUNTY P.G.	23f. STATE Maryland		
24. FUNERAL DIRECTOR NAME F. Gasch's Sons F.H. P.A.	ADDRESS Hyattsville, Maryland	25a. DATE REC'D. BY REGISTRAR APR 14 1986	25b. REGISTRAR'S SIGNATURE <i>John J. Pendleton</i>				

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 2 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18, AND 3 TO THE FUNERAL DIRECTOR.
 PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3, RETAIN PAGE 5 FOR YOUR FILES.
 TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS, AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE												REG. NO. 12263			
1- STATE REGISTRAR Bruce Oliver Jarvis				MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE KNOWN OF ESTI- DEATH MATED		MONTH DAY YEAR					
Bruce Oliver Jarvis								<input checked="" type="checkbox"/>		April 19 1986					
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YR. MONTHS DAYS		8. IF UNDER 24 HRS. HOURS MIN		2c. DATE PRONOUNCED DEAD			
M		W		11/21/36		49 (RS.)						April 19 1986			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED		9. BALTIMORE CITY OR COUNTY OF DEATH									
Maryland		U.S.A.				Prince George									
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)								12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
Lanval		116 Main St.								Maintenance		General			
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS		20810					
MD		Prince George		Lanval				116 Main St.							
14. FATHER'S NAME FIRST		MIDDLE		LAST		15. MOTHER'S MAIDEN NAME FIRST		MIDDLE		LAST					
Theodore		R.		Jarvis		Nettie		G.		Stafford					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic Alcoholism DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) DUE TO, OR AS A CONSEQUENCE OF (c)									
Yes		1955-1960		213-32-2479		Ellen Mackay 1506 Spruce St Apt 3		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (o) None															
19a. DATE OF OPERATION None		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>															
ACTUAL SIGNATURE Dr. J. Gonce		TITLE (SPECIFY) M.D. Dr. J. Gonce, MEDICAL EXAMINER								DATE SIGNED April 19 1986					
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS													
23a. BURIAL-CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL		23d. LOCATION CITY OR TOWN		23e. COUNTY		23f. STATE					
Burial		4/24/86		Md Veterans Cemetery		Crownsville		A.A.		Md					
24. FUNERAL DIRECTOR NAME George J. Gonce		ADDRESS 4001 Ritchie Hwy Balto Md		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE									
				APR 25 1986		John G. Gonce									

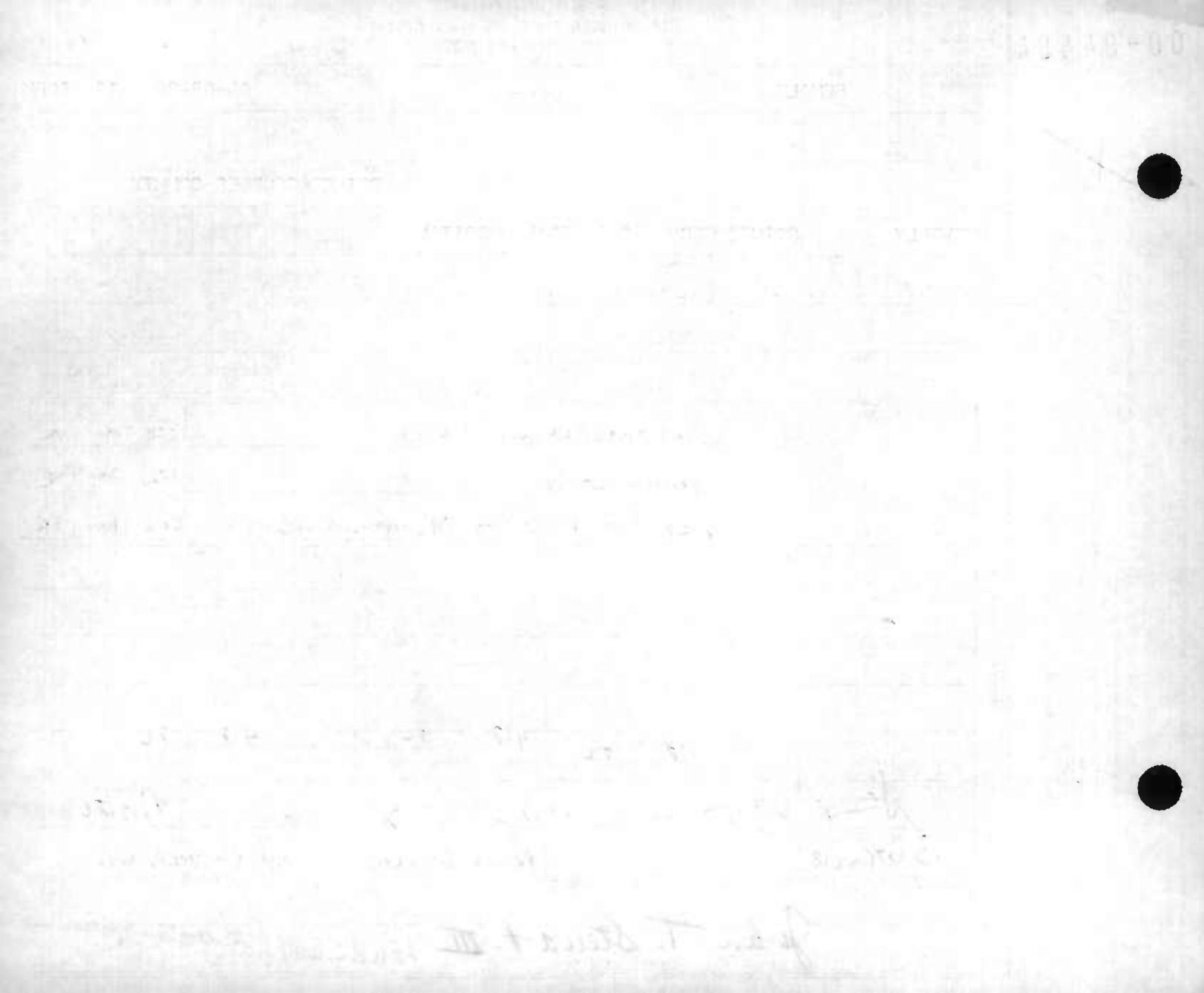
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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8612264
REG. NO.1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2d. DATE OF DEATH	MONTH	DAY	YEAR	2d. HOUR
			FEMALE JOHNSON			04-08-86			12 :50PM M	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR	
Female		Black		Month Day Year April 8, 1986		YRS			IF UNDER 24 HRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGES COUNTY MD				
Maryland		United States								
10. CITY OR TOWN OF DEATH CHEVERLY		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION PRINCE GEORGE'S GENERAL HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) None			12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE Maryland		13c. CITY OR TOWN P. G.		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 1604 Marblewood Avenue 20785-				
14. FATHER'S NAME James		FIRST MIDDLE LAST Johnson		15. MOTHER'S MAIDEN NAME Verbel			LAST Brewington			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. None		17. INFORMANT Verbel Johnson, mother, 1604 Marblewood Avenue			ADDRESS Landover, Maryland			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIO RESPIRATORY ARREST										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH LESS THAN 1 HR.
DUE TO, OR AS A CONSEQUENCE OF (b) IMMATURITY										Less Than 1 HR.
DUE TO, OR AS A CONSEQUENCE OF (c) ABRUPTUS PERTINA, SPONTANEOUS ABORTION										Less Than 1 HR.
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN	COUNTY	STATE		
22a. I certify that (I) (his/his) attended the deceased from <u>4/18</u> , 19 <u>86</u> , to <u>4/19</u> , 19 <u>86</u> , that (I) (we) last saw the deceased alive on <u>4/18</u> , 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <u>S. Wyner</u>		DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/>		MEDICAL DIRECTOR <input type="checkbox"/>	STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED 4/17/86		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) S. Wyner		22e. ADDRESS Prince Georges Gen. Hosp, Cheverly MD								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) cremation		23b. DATE Apr. 18, 1986		23c. NAME OF CEMETERY OR CREMATORIUM Lee's Crematorium		23d. LOCATION CITY OR TOWN Washington, COUNTY D.C. STATE				
24. FUNERAL DIRECTOR NAME John Stewart, III		ADDRESS Stewart Funeral Home 4001 Benning Road, N.E.		25a. DATE REC'D. BY REGISTRAR APR 23 1986		25b. REGISTRATION NUMBER 12264				
BP _____										
DHMH - 16 60M 7/84 (VRA 15, 4)										



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be secured within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, the burial trustee agent, the funeral director, and the medical examiner, it should be forwarded for use at the burial trustee agent. Then please issue carbon copies. Pages 1 and 2 should be used within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other final disposition.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other finalistic event, the medical examiner must be immediately informed.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
REG. NO. 8612265											
1 - STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT)			FIRST Jay		MIDDLE M		LAST Johnson		2a. DATE OF DEATH April 23, 1986
3. SEX male		4. RACE white		5. DATE OF BIRTH MONTH March DAY 23 YEAR 1923			6. AGE (IN YEARS LAST BIRTHDAY) 63		2b. HOUR 10:45 P M		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Tennessee		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Prince Georges County MD.				
10. CITY OR TOWN OF DEATH Laurel		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Greater Laurel Beltsville Hospital			12a. USUAL OCCUPATION machinist			12b. KIND OF BUSINESS OR INDUSTRY Westinghouse			
13a. SUCIAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland		13b. COUNTY Howard		13c. CITY OR TOWN Jessup		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 2044 Horseshoe Circle 20794			
FATHER'S NAME FIRST Edgar		MIDDLE Wilson		LAST Johnson		15. MOTHER'S MAIDEN NAME Henrietta		Bailey			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (IF UNKNOWN) YES		16b. SOCIAL SECURITY NO. WW 2		17. INFORMANT Alice Johnson same as above			ADDRESS				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiorespiratory arrest APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
DUE TO, OR AS A CONSEQUENCE OF (b) CHF											
DUE TO, OR AS A CONSEQUENCE OF (c) Cardiac arrhythmia											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?				
					YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)						
21d. INJURY OCCURRED <input type="checkbox"/> AT HOME <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM ETC.)			21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE
22a. I certify that (I) (this hospital) attended the deceased from 3 16, 1986, to 4 23, 1986, that (I) (we) last saw the deceased alive on 4 23, 1986, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Dr Jalal Fatemi		DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED May 20 1986				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr Jalal Fatemi		22e. ADDRESS 5632 Anna Polis Rd #12 Bladensburg									
23a. BURIAL, CREMATION, REMOVAL burial		23b. DATE 4-26-86		23c. NAME OF CEMETERY OR CREMATORIAL Meadowridge Mem. Park			23d. LOCATION CITY/TOWNSHIP Dorsey		COUNTY Maryland		
24. FUNERAL DIRECTOR NAME Donaldson Funeral Home P.A.		ADDRESS Laurel, Maryland			25a. DATE REC'D. BY REGISTRAR APR 29 1986		25b. REGISTRAR'S SIGNATURE Julie Deirdre Powers				
(VRA 15, 4)											

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

RE-03563
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-trust permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death.

IMPORTANT! If item 21 is marked ✓, show any injury, or other traumatic event, the medical examiner must be notified promptly.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REC. NO. 2266		
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2d. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR		
ROBERTA					JOHNSON	APRIL			4	4	86	I 03AM		
3. SEX			4. RACE		5. DATE OF BIRTH			MONTH	DAY	YEAR	6. AGE (IN YEARS LAST BIRTHDAY)			
FEMALE			BLACK		MARCH 21, 1921						IF UNDER 1 YEAR MONTHS DAYS			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?		8			MARRIED <input type="checkbox"/>	NEVER MARRIED <input type="checkbox"/>	WIDOWED <input checked="" type="checkbox"/>	DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGE COUNTY MD.		
Virginia			United States											
10. CITY OR TOWN OF DEATH CHEVERLY			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) PRINCE GEORGE GENERAL HOSPITAL					12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Laundress			12b. KIND OF BUSINESS OR INDUSTRY Clothing			
13a. STATE Maryland			13b. COUNTY PG	13c. CITY OR TOWN Hyattsville	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE 6847 Forrest Terrace 20785						
14. FATHER'S NAME Stanup			MIDDLE	LAST	15. MOTHER'S MAIDEN NAME Florence			FIRST	MIDDLE	LAST	Taylor			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 229-05-7103		17. INFORMANT Jean Woodley-Daughter-4800 Birchtree Lane			ADDRESS Temple Hills, Md.						
18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c.) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebral Vascular Accident</u>												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause, if any.														
(b) <u>Hypoxic Encephalopathy</u>														
{ DUE TO, OR AS A CONSEQUENCE OF (c) <u>Hypertension</u>														
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a <u>Seizure Disorder</u>														
19a. MEDICAL CERTIFICATION DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY	STATE	
22a. I certify that (if this hospital) attended the deceased from saw the deceased alive on 4/3/86, and that in (my) our opinion death occurred on the date and hour and from the causes stated above (I/we) (did) did not view the body after death.												22c. DATE SIGNED 4/3/86		
22b. SIGNATURE Stuart Turbeville			DEGREE MD			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22d. DATE SIGNED 4/3/86					
22e. ADDRESS 8500 Greenway Center Dr. Greenbelt, Md. 20770														
23a. BURIAL, CREMATION, REMOVAL BURIAL			23b. DATE 4/7/86			23c. NAME OF CEMETERY OR CREMATORIAL Cheltenham Vet CEM.			23d. LOCATION CITY OR TOWN CHELTENHAM			COUNTY	STATE	
24. FUNERAL DIRECTOR NAME ALEXANDER S. POPE ADDRESS Foggy Funeral Home						24e. CERTIFIED BY REGISTRAR OR REGISTRAR'S SIGNATURE MERRILL J. JULIA								



MEDICAL EXAMINER NOTIFIED

retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, then please remove carbon papers. Pages 1 and 2 should be detached for use as the burial/transit permit.

with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal of the body.

IMPORTANT: If Item 21 is marked or if there is a showing of injury, or other traumatic event, the medical examiner must be notified of the same.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH																		
1- FOR STATE REGISTRAR		REC. NO. 12257																
I. DECEASED NAME (TYPE OR PRINT)		FIRST WILLIAM			MIDDLE		LAST JOHNSON		2a. DATE OF DEATH		MONTH 04		DAY 18		YEAR 86		2b. HOUR 9 : 58AM	
3. SEX Male		4 RACE Black			5. DATE OF BIRTH MONTH March		DAY 6		YEAR 1919		6. AGE (IN YEARS LAST BIRTHDAY) 67		YRS		IF UNDER 1 YEAR		IF UNDER 24 HRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia		7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input checked="" type="checkbox"/>		NEVER MARRIED <input type="checkbox"/>		WIDOWED <input type="checkbox"/>		DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGE'S					
10. CITY OR TOWN OF DEATH CHEVERLY		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) PRINCE GEORGE'S GENERAL HOSPITAL			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired		12b. KIND OF BUSINESS OR INDUSTRY 999999											
13a. STATE Washington, D.C.		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 3298 Ft. Lincoln Drive, N.E.										
14. FATHER'S NAME FIRST Wilbert MIDDLE Johnson		LAST		15. MOTHER'S MAIDEN NAME FIRST Lelia MIDDLE Venable		LAST												
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. 224 07 7123		17. INFORMANT Sallie R. Johnson-wife-3606 Rock Cre		ADDRESS		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH										
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CAD c Possible Acute MI		DUE TO, OR AS A CONSEQUENCE OF (b) Hypertensive Cardio-		DUE TO, OR AS A CONSEQUENCE OF (c) vascular disease														
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) CA of prostate c metastasis , old CVA																		
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>											
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)													
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE							
22a. I certify that (I) (this hospital) attended the deceased from 3-28-1975 , to 2-25-1986 , that (I) (we) lost saw the deceased alive on 2-25-1986 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																		
22b. SIGNATURE H.A. Molavi, M.D.		DEGREE M.D.		ATTENDING PHYSICIAN <input checked="" type="checkbox"/>		MEDICAL DIRECTOR <input type="checkbox"/>		STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 4-18-86								
22d. PHYSICIAN'S NAME (TYPE OR PRINT) HASSAN. A. MOLAVI, M.D.		22e. ADDRESS 6005 Landover Rd. Cheverly, MD 20785																
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE April 24, 1986		23c. NAME OF CEMETERY OR CREMATORIUM Fort Lincoln Cemetery		23d. LOCATION CITY OR TOWN Brentwood, Md.												
24. FUNERAL DIRECTOR NAME John T. Stewart III		25a. DATE REC'D. BY REGISTRAR APR 23 1986		25b. REGISTRAR'S SIGNATURE Jeanne Davidson-Pendleton														
Stewart Funeral Home-4001 Benning Road, NE																		

999999
BP

3m Dark Brown to grey

- smooth
- white

2m Light Brown to grey

- smooth
- white

1.25 25.2 - 25.2 25.2 25.2

27.81 +
28.52 28.52 28.52 28.52 28.52

00-05719

DIVISION OF VITAL RECORDS 301 W. PRESTON ST., BALTIMORE MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM B. OF PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES.
TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT FORM. PAGES 1 AND 2 SHOULD BE FILLED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DIVISION OF HEALTH AND MENTAL HYGIENE, DIVISION OF FUNERAL RECORDS, 201 W. JEFFERSON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION OR REMOVAL.

MEDICAL CERTIFICATION

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST			2a DATE KNOWN OF ESTI- MATED	MONTH	DAY	YEAR	2b HOUR
Willie					Jordan			<input checked="" type="checkbox"/>	4	4	19	86
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YR.	IF UNDER 24 HRS.			2c. DATE PRONOUNCED DEAD	MONTH	DAY	YEAR	2d HOUR
Male	Black	Jul 23 1961	24 yrs.	MONTHS	DAYS	HOURS	MIN.	<input checked="" type="checkbox"/>	4	4	19	86
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?			8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH				
Dist of Colum		U.S.A.						Prince George's				
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY				
Capitol Heights		Dead end - Bend St.			Housekeeping			Private				
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)												
13a. STATE	13b. COUNTY	13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS			20785			
Maryland	P. G.	Landover				3408 Dodge Park			Bad			
14. FATHER'S NAME FIRST		MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST			16. SOCIAL SECURITY NO.		17. INFORMANT	ADDRESS		
Joseph			Jordan	Mary			577-90-0842		Mary Jordan	1150-12th ST., NW., DC.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY:												
IMMEDIATE CAUSE (a) _____ Hanging APPROXIMATE INTERVAL DUE TO, OR AS A CONSEQUENCE OF BETWEEN ONSET AND DEATH												
Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause lost. (b) _____												
DUE TO, OR AS A CONSEQUENCE OF (c) _____												
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20 AUTOPSY?		
21a EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 4 4 19 86			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) Sal-de-sac			21f. LOCATION STREET Dead end-Bend St.			CITY OR TOWN	COUNTY	STATE		
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <i>John E. Smialek</i> TITLE (SPECIFY) M.D. Chief MEDICAL EXAMINER DATE SIGNED 4-5-86												
EXAMINER'S NAME (TYPE OR PRINT)		John E. Smialek, M.D.			ADDRESS			111 Penn St., Balt., MD. 21201				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN		COUNTY		STATE	
Burial		04/12/86		Harmony Mem. Park			Hyattsville (PG) - Md.					
24. FUNERAL DIRECTOR NAME		ADDRESS			3619-14th ST., NW			25. DATE REC'D. BY REGISTRAR				REGISTRAR'S SIGNATURE
Lawrence W. Plunkett, Inc.		Wash., D.C.						MAY 01 1986				

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TO HOSPITAL OR ATTENDING PHYSICIAN The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR After this certificate has been signed by the attending physician and completed, it should be detached for use on the burial/transit permit. Then please remove carbon papers. Page 4 may be retained by the funeral director with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked "No" on Item 18 shows any injury, or other traumatic event, the medical certifying physician must sign this section.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												
8 0 1 2 2 6 9 REG. NO.												
1 - STATE REGISTRAR			1 DATE OF DEATH MONTH DAY YEAR			2b HOUR						
1 DECEASED NAME <small>(LAST, FIRST, MIDDLE)</small>			Shin Woo KANG			April 12, 1986			1:30 AM			
3 SEX		4 RACE		5 DATE OF BIRTH MONTH DAY YEAR			6 AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR MONTHS DAYS		
Male		Oriental		Sept 2, 1924			61			IF UNDER 24 HRS HOURS MIN.		
7a BIRTHPLACE <small>COUNTRY</small>		7b CITIZEN OF WHAT COUNTRY?			8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH				
Korea		Korea						Prince George County MD.				
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION <small>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)</small>			12a USUAL OCCUPATION <small>(TYPE OF WORK FOR MOST OF WORKING LIFE)</small>			12b KIND OF BUSINESS OR INDUSTRY				
Lanham		Doctor's Hospital of P.G. Co. Brick Maker									construction	
13a STATE		13b CITY OR TOWN		13c CITY OR TOWN			13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e STREET ADDRESS / ZIP CODE		
Maryland		Prince George		Berwyn Heights			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			8423 54th Av., 20740		
14. FATHER'S NAME FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST									
Duk Hi Kang			Boo O. Yoon									
16a WAS DECEASED EVER IN U.S. ARMED FORCES? <small>(YES, NO OR UNKNOWN)</small>			16b SOCIAL SECURITY NO.			17. INFORMANT			18. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
no			213 11 0081			Yusok Kang, 11625 Twining Lane,						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Stroke with left hemiplegia</i>												
DUE TO, OR AS A CONSEQUENCE OF (b) <i>Re-stal bleeding</i>												
DUE TO, OR AS A CONSEQUENCE OF (c) <i>Pneumonia</i>												
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)												
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH <small>(IF EITHER NOTIFY MEDICAL EXAMINER)</small>		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f LOCATION STREET			CITY OR TOWN COUNTY STATE				
22a I certify that (I) (this hospital) attended the deceased from <i>April 10, 1986</i> , to <i>April 11, 1986</i> , that (I) (we) last saw the deceased alive on <i>April 11, 1986</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE		DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED				
<i>ZK Yoon MD</i>											<i>4/12/86</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS										
<i>Yeon-Kwon H. Yoon</i>		<i>5506 Kenilworth Ave. Livuckle Md. 20751</i>										
23a. BURIAL, CREMATION, REMOVAL <small>(SPECIFY)</small>		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN			23e. COUNTY STATE		
Burial		1986 April 16,		Gate of Heaven Cemetery Silver Spring, Maryland								
24. FUNERAL DIRECTOR NAME		Robert A. Pumphrey Funeral Homes, ADDRESS			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE				
		P.A. 300 W. Montgomery Av., Rockville, Md.									<i>Robert A. Pumphrey</i>	
BP _____					APR 16 1986							
DHMH - 16 60M 7/84 (VRA 15, 4)												

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1962

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be referred to by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the Burial Permit. Then please remove carbon paper. Page 4 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on Item 18 (show only injury or other traumatic event, the medical certification section must be completed).

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 86 12270								
1. FOR STATE REGISTRAR			1. DECEASED NAME FIRST Susan					MIDDLE Kathryn		LAST Kastner		2a. DATE OF DEATH April 15 1986			MONTH DAY YEAR	2b. HOUR APRIL 3:00 P.M.		
3. SEX female			4. RACE caucasian			5. DATE OF BIRTH MONTH Oct. 25			DAY 1897	YEAR	6. AGE (IN YEARS LAST BIRTHDAY) 88			IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.		
7a. BIRTHPLACE COUNTRY Balto. Md.			7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's			MD.						
10. CITY OR TOWN OF DEATH Laurel			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Greater Laurel Beltsville Hosp.			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired			12b. KIND OF BUSINESS OR INDUSTRY D.C.Gov't									
13a. STATE Md.			13b. COUNTY P.G.			13c. CITY OR TOWN Laurel			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS 507 Prince George St.						
14. FATHER'S NAME FIRST James			MIDDLE LAST McDonnal			15. MOTHER'S MAIDEN NAME FIRST Virginia			16. SOCIAL SECURITY NO. 220-44-8410			17. INFORMANT Susan Poe			ADDRESS 203 10th St.			
18a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no			18b. PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)			18c. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH												
			CARDIO PULMONARY ARREST															
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			(b) SUDDEN CARDIAC DEATH															
			(c)															
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																		
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)												
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE												
22a. I certify that (I) (this hospital) attended the deceased from 1985 to 1986 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. I did not see the body after death.																		
22b. SIGNATURE GREGORY A. COMPTON										DEGREE MD	ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/>	STAFF	22c. DATE SIGNED 4-16-86					
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS															
Gregory A. Compton, M.D. 14201 Laurel Park Dr., Laurel, MD 20707 #221																		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 4/19/86			23c. NAME OF CEMETERY OR CREMATORIUM Ivy Hill Cemetery			23d. LOCATION CITY OR TOWN Laurel			COUNTY P.G.	STATE Md.					
24. FUNERAL DIRECTOR NAME FLECK F.A. INC.			25a. DATE OF REGISTRATION APR 18 1986			25b. REGISTRATION NUMBER 11												

00-03418

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGES 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE TILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DIVISION OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO. 2271				
1- STATE REGISTRAR			1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			20. DATE KNOWN OF ESTI- DEATH MATED			REG. NO. 2271				
			Mary EDITH Keavney						<input checked="" type="checkbox"/> MONTH DAY YEAR			2b. HOUR				
3. SEX			4. RACE			5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS) LAST BIRTHDAY MONTHS DAYS HOURS MIN.			2c. DATE PRONOUNCED DEAD			2d. HOUR MONTH DAY YEAR	
F W			W			10 30 1948 37						4-9 1986			3:40 p.m.	
7b. BIRTHPLACE STATE OR FOREIGN COUNTRY			7b. CITIZEN OF WHAT COUNTRY?			8.			9. BALTIMORE CITY OR COUNTY OF DEATH			Prince George's County, MD.				
BALTO. MD.			U.S.A.			MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>										
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY							
Upper Marlboro			17016 Fairway View			AT Home										
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS				
MD.			PRINCE GEORGES			UPPER MARLBORO						17016 FAIRWAY VIEW 20870				
14. FATHER'S NAME FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO			16b. SOCIAL SECURITY NO. 220-54-6518			17. INFORMANT ADDRESS FAMILY RECORDS				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Narcotism DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)															APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).																
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>										
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)										
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE										
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																
ACTUAL SIGNATURE Dennis F. Smyth, M.D.															TITLE (SPECIFY) M.D. Assistant MEDICAL EXAMINER	
EXAMINER'S NAME (TYPE OR PRINT) Dennis F. Smyth, M.D.															DATE SIGNED 4-10-86	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE APRIL 12, 1986			23c. NAME OF CEMETERY OR CREMATORIAL NEW CATHEDRAL CEM.			23d. LOCATION CITY OR TOWN BALTO. CITY			COUNTY MD STATE				
24. FUNERAL DIRECTOR NAME			EVANS CHAPEL OF MEMORIES						25a. DATE REC'D. BY REGISTRAR APR. 14 1986			25b. REGISTRAR'S SIGNATURE				
DHMH - 17 (VR A15 ME (5))																

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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO.					
DECEDENT'S NAME			FIRST	MIDDLE	LAST	DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR					
James Frederick Keir						April 6, 1986						P 3:50 M					
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS					
Male		White		March 7, 1910			76			MONTHS	DAYS	HOURS	MIN.				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.							
Washington D.C.		U.S.A.					Prince George's County										
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY									
Riverdale		Belmont Memorial Hospital						Postal Worker			U.S. Gov't.						
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE								
Maryland		Prince Geo.		Greenbelt					10-D Parkway Road 20770								
14. FATHER'S NAME		FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME			16. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
Alfred				Keir	Emma						Maisch						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.			17. INFORMANT			18. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
No		217-36-5801			9522 49th Avenue James M. Keir, College Park, Maryland												
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Sepsis + Aspiration of Blood												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
912 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Upper GI Bleed (c) Recurrent Esophageal Varices; Liver Cirrhosis																	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Myocardial Infarction 12/85																	
19a. MEDICAL CERTIFICATION		19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?							
							YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b. PART 1 OR PART 2)			21d. LOCATION STREET CITY OR TOWN COUNTY STATE									
21d. INJURY OCCURRED AT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)															
22a. I certify that (in this hospital) attended the deceased from 4/1/86 to 4/6/86 , saw the deceased alive on 4/6/86 and that in (my) our opinion death occurred on the date and hour and from the causes stated above. (I/we) did not view the body after death.																	
22b. SIGNATURE Stuart J. Turkewitz, M.D.		22c. DEGREE						22d. DATE SIGNED									
								April 7, 1986									
22e. ADDRESS								22f. ADDRESS									
7500 Greenway Ctr. Dr. #430 Greenbelt, Md.								7500 Greenway Ctr. Dr. #430 Greenbelt, Md.									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN COUNTY STATE			23e. DATE REC'D. BY REGISTRAR				23f. REGISTRAR'S SIGNATURE			
Burial		4-9-86		Ft. Lincoln Cemetery			Brentwood, P.G., Maryland			APR 09 1986				Julia Dawson-Pandele			
24. FUNERAL DIRECTOR NAME F. Gasch's Sons F.H. P.A.		ADDRESS Hyattsville, Maryland															

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 18 is marked or Item 18 shows any injury, or other traumatic event, the medical certifying physician must sign this certificate.

book library

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Autumn 1902 series

Father [unclear] [unclear]

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book library

The following are all additions made since the previous statement

University of Illinois at Urbana-Champaign

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. If more than 24 hours elapse, the attending physician should be notified for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be held within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, it may be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. If item 18 shows any injury, or other traumatic event, the medical examiner should be notified.

IMPORTANT: If item 21 is marked

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 86122732											
1 - STATE REGISTRAR			2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR												
1. DECEASED NAME (TYPE OR PRINT)			LAST			4-5-86			7-10 AM												
Donald Brown Kern Jr																					
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			7. IF UNDER 1 YEAR MONTHS DAYS		8. IF UNDER 24 HRS HOURS MIN									
Male		Caucasian		Month October 23, 1922 Year			63														
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.											
Virginia		U.S.A.					Prince George's														
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY														
Clinton		Southern Maryland Hospital Center		Auto Mechanic			Standard Oil Co.														
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)										20735											
13a. STATE Maryland		13b. COUNTY Prince George		13c. CITY OR TOWN Clinton			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE 6200 Edward Drive											
14. FATHER'S NAME FIRST Elwood		MIDDLE Kern		15. MOTHER'S MAIDEN NAME FIRST Nellie			MIDDLE Lee														
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO. No 578-22-0966		17. INFORMANT Dorothy M. Kern			18. ADDRESS 6200 Edward Dr. Clinton, Maryland														
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Myocardial infarction</i>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 hr											
DUE TO, OR AS A CONSEQUENCE OF (b) <i>General Circulatory and arterial disease</i>										4 yrs											
DUE TO, OR AS A CONSEQUENCE OF (c) <i>Angina</i>																					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a																					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>													
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)																
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY		STATE								
22a. I certify that (I) (this hospital) attended the deceased from 6 27 19 26 to 4-5-86, that (we) last saw the deceased alive on 3-29 19 86, and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) (did not) see the body after death.																					
22b. SIGNATURE <i>R. Dobson MD</i>										DEGREE			22c. DATE SIGNED 4-5-86								
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Richard H. Dobson, M.D.										ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial										23b. DATE 4/8/86			23c. NAME OF CEMETERY OR CREMATORIAL Cedar Hill Cemetery			23d. LOCATION CITY OR TOWN Suitland			COUNTY P.G.		STATE Maryland
24. FUNERAL DIRECTOR NAME George P. Kalas Funeral Home										6160 Oxon Hill Rd. Oxon Hill, Md.			25a. DATE REC'D. BY REGISTRAR APR 09 1986			25b. REGISTRAR'S SIGNATURE <i>George P. Kalas</i>					
DHMH 16 60M 7/84 (VRA 15, 4)																					

May 19
Gardens 55' 1955
Geoptex 55' 1955
Gardens 55' 1955

U.S.A. MATTER OF THE STATE OF NEW YORK v. ROBERT WILSON, JR.

28325
Gifford
Robert W. (Right) Hobbs & Associates

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10 HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

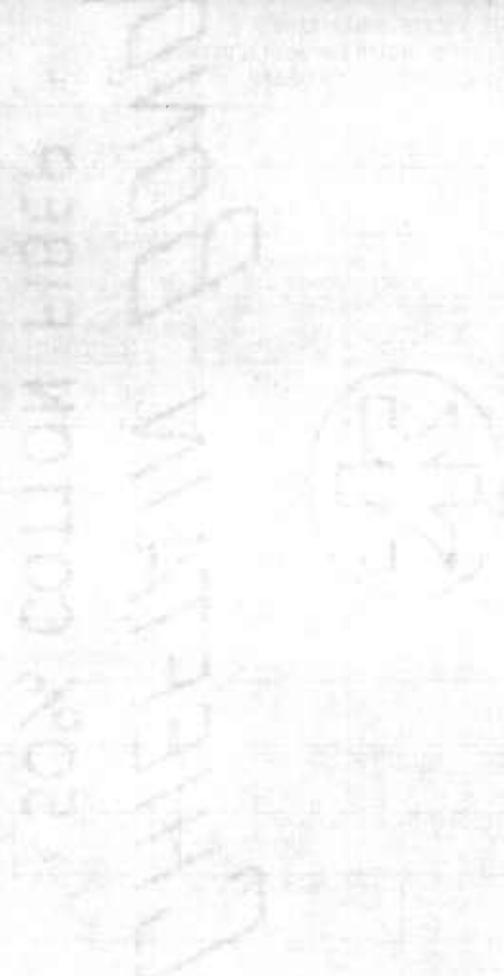
TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked on Part 1B skip any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH						REG. NO. 8612274	
1. DECEASED NAME (TYPE OR PRINT)			FIRST Soon	MIDDLE Kim	LAST	2a. DATE OF DEATH MONTH DAY YEAR April 22, 1986	2b. HOUR 3:40 P.M.
3. SEX Female		4. RACE Korean	5. DATE OF BIRTH MONTH DAY YEAR Feb. 14, 1927		6. AGE (IN YEARS LAST BIRTHDAY) IF UNDER 1 YEAR MONTHS DAYS	7b. HOUR 3:40 P.M.	
7a. BIRTHPLACE COUNTRY Korea		7b. CITIZEN OF WHAT COUNTRY? Korea	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince George		
10. CITY OR TOWN OF DEATH Hyattsville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 3413 Tulane Drive				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker	
13a. STATE Md.		13b. COUNTY PG	13c. CITY OR TOWN Hyattsville		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 3413 Tulane Drive 20783	
14. FATHER'S NAME FIRST Kuk		MIDDLE Pil	LAST Kim	15. MOTHER'S MAIDEN NAME FIRST Soon		MIDDLE Nam	LAST Lee
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) N/A		16b. SOCIAL SECURITY NO. N/A		17. INFORMANT Young Yoo (Son) Same as 13e		18. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Metastatic Cancer of abdomen. DUE TO, OR AS A CONSEQUENCE OF (b) Uterine cancer DUE TO, OR AS A CONSEQUENCE OF (c) Hydronephrosis							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a							
19a. DATE OF OPERATION 4/17/86		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Poor			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET	CITY OR TOWN	COUNTY	STATE
22a. I certify that (I) (this hospital) attended the deceased from 7/20/83 , 19 4/17/86 , 19 4/17/86 , that (I) (we) last saw the deceased alive on 4/17/86 , 19 4/17/86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>Dr. Year-Kwon Yoon</i>		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 4/23/86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Year-Kwon Yoon		22e. ADDRESS 5506 Kenilworth Ave. Riverdale Md.					
23a. BURIAL, CREMATION, REMOVAL Cremation		23b. DATE 4/25/86	23c. NAME OF CEMETERY OR CREMATORIAL Lee's Crematory		23d. LOCATION Washington, D.C.	23e. STATE D.C.	
24. FUNERAL DIRECTOR Hines Rinaldi		24b. DATE REC'D. BY REGISTRAR APR 25 1986		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

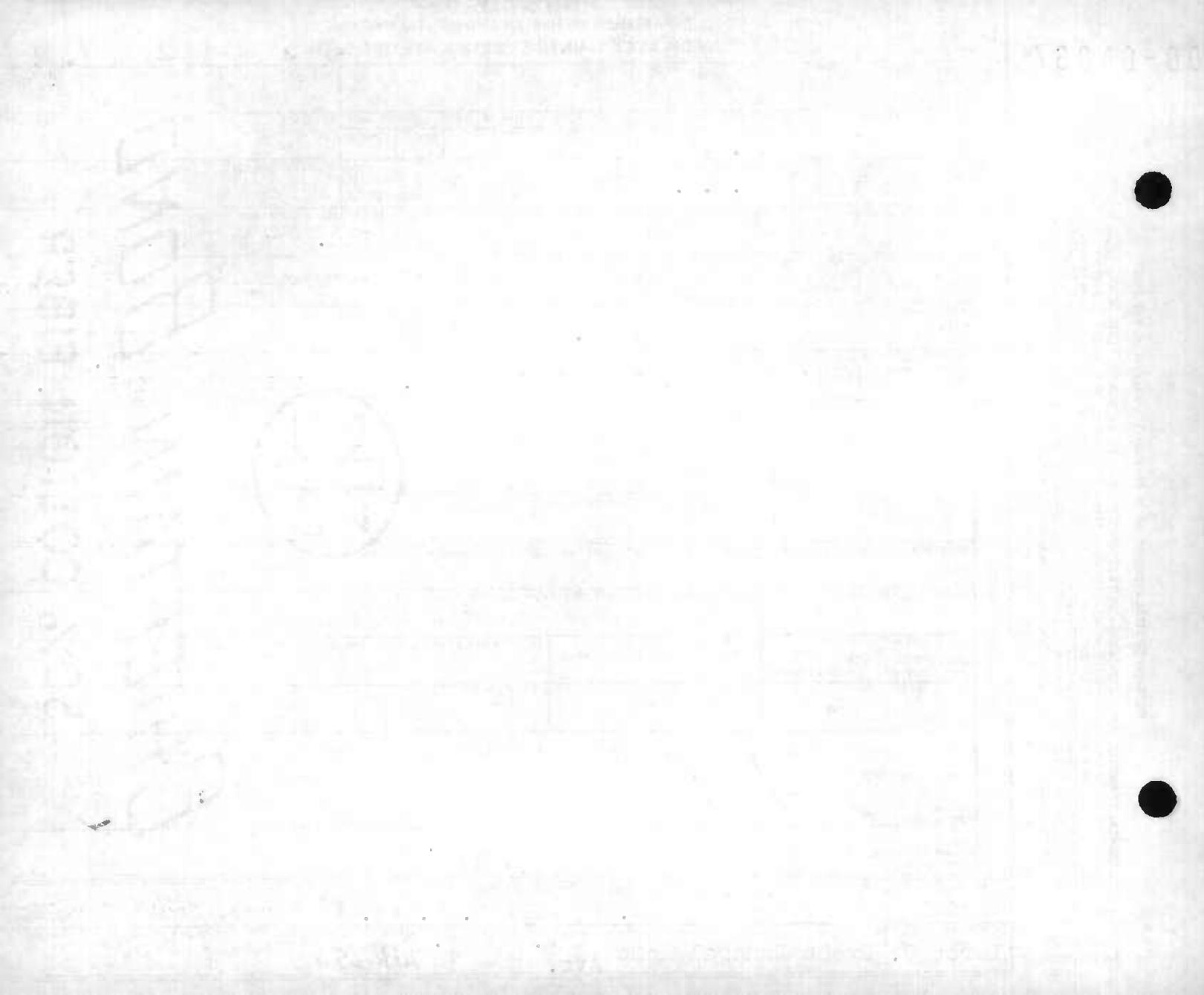
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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND; 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO. 2275	
1 - STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT)						2a. DATE KNOWN OF ESTI. DEATH MATED					
		Elizabeth			A.			King			<input checked="" type="checkbox"/> MONTH DAY YEAR 4/21/86		
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YR. MONTHS DAYS		8. IF UNDER 24 HRS. HOURS MIN.		2b. HOUR 10:1	
Female		Black		Oct. 2, 1943		42 yrs.						4/21/86 P M	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?						9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's County, MD.					
South Carolina		U.S.A.											
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)					
Cheverly		Prince George's General Hospital						12b. KIND OF BUSINESS OR INDUSTRY Fed. Trade Comm. Trade Comm					
13a. STATE		13b. COUNTY		14. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 60201 3705 Kempsford Field Place					
Maryland		Charles		Waldorf									
14. FATHER'S NAME		MIDDLE		LAST		15. MOTHER'S MAIDEN NAME		16. ADDRESS San Ant. TX78251					
Julius				Evans, Sr.		Elease		John E. Evans 1910 Cpperfield Rd.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Gunshot Wound of Chest DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the <u>under-</u> <u>lying cause lost.</u>												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
(b) DUE TO, OR AS A CONSEQUENCE OF													
(c)													
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?										20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR AM/M PM MONTH DAY YEAR 9:15 P.M. 4/21/86		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART 1 OR PART 2) subject shot									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) home		21f. LOCATION STREET 3705 Kempsford Fields Pl., Waldorf, CharlesCo.,		CITY OR TOWN		COUNTY		STATE Md.			
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural cause <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>													
ACTUAL SIGNATURE 												TITLE (SPECIFY) M.D. Assistant MEDICAL EXAMINER	DATE SIGNED 4/22/86
EXAMINER'S NAME (TYPE OR PRINT)		Gregory R. Kauffman, M.D.										ADDRESS 111 Penn St.	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE 4/28/86		23c. NAME OF CEMETERY OR CREMATORIAL Mt. Zion Bapt.Ch.Cen.		23d. LOCATION CITY OR TOWN Eastover,		23e. COUNTY South Carolina		23f. STATE			
Burial													
24. FUNERAL DIRECTOR NAME		ADDRESS		4600 Lib. Hghts. Ave.		24a. DATE REC'D. BY REGISTRAR Apr 25/86		25b. REGISTRAR'S SIGNATURE 					
Leroy O. Dyett Funeral Home													



00-02930

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

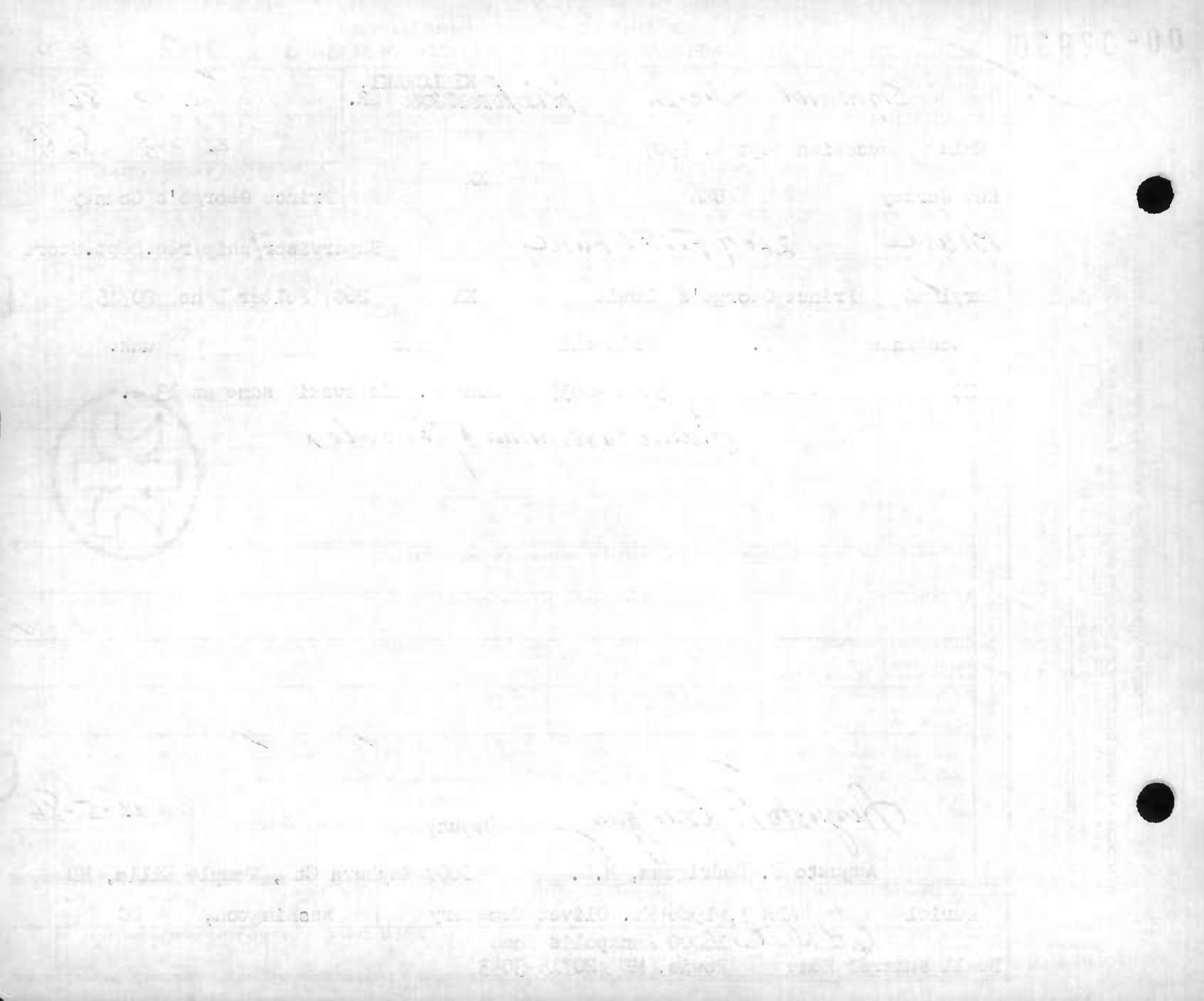
REG. NO.

2276

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B, GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3 RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILLED WITHIN 72 HOURS AFTER DEATH WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR RECAVAL.

MEDICAL CERTIFICATION

1. DECEASED NAME (TYPE OR PRINT)		FIRST <i>Sigmund Joseph</i>	MIDDLE <i>Kislowski</i>	LAST <i>Kislowski SR.</i>	2a. DATE KNOWN OF ESTI- MATED	MONTH <input type="checkbox"/> APR	DAY <input type="checkbox"/> 3	YEAR <input type="checkbox"/> 1986	2b HOUR		
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY) YRS.	7. IF UNDER 1 YR. MONTHS DAYS	8. IF UNDER 24 HRS. HOURS MIN				2d. DATE PRONOUNCED DEAD		
Male	Caucasian	Sept 4, 1907	78						4 - 3 1986		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			
New Jersey		USA						Prince George's County MD.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY		
Baltimore		2607 Felter Lane				Supervisor/ship/rec. Dept. Store					
13a. STATE		13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS					
Maryland		Prince George's	Bowie			2607 Felter Lane 20715					
14. FATHER'S NAME FIRST		MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST		MIDDLE	LAST				
Costanza		J.	Kislowski	Agnes			unk.				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS					
NO		136-07-0635		Edna M. Kislowski		same as 13 e.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Adenocarcinoma of the colon</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
(b) <i></i> DUE TO, OR AS A CONSEQUENCE OF											
(c) <i></i>											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY?			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY	STATE		
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <i>Augusto P. Rodriguez</i>										TITLE (SPECIFY) M.D. Deputy	MEDICAL EXAMINER
EXAMINER'S NAME (TYPE OR PRINT) <i>Augusto P. Rodriguez, M.D.</i>										ADDRESS <i>5009 Rayburn Ct., Temple Hills, MD</i>	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE <i>APR 7, 1986</i>	23c. NAME OF CEMETERY OR CREMATORIAL <i>Mt. Olivet Cemetery</i>		23d. LOCATION CITY OR TOWN <i>Washington, DC</i>		COUNTY	STATE			
24. FUNERAL DIRECTOR NAME <i>Keith McLean</i>		ADDRESS <i>16000 Annapolis Road Beall Funeral Home Bowie, MD 20715-3043</i>		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE <i>APR 08 1986</i>					



00-04174

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

86 REC. NO.

12277

1. FOR STATE REGISTRAR											
1. DECEASED NAME (TYPE OR PRINT)		FIRST JUSTIN		MIDDLE J.		LAST KLEM		20. DATE OF DEATH MONTH DAY YEAR 04-16-86		2b. HOUR 11 :00AM	
3. SEX Male		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR May 29 1913		6. AGE (IN YEARS LAST BIRTHDAY) 72 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE COUNTRY New York		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGE'S COUNTY		MD.			
10. CITY OR TOWN OF DEATH CHEVERLY		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION PRINCE GEORGE'S GENERAL HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Photo Processing		12b. KIND OF BUSINESS OR INDUSTRY Self Employed			
13a. STATE Maryland		13b. COUNTY Pr. Geo.		13c. CITY OR TOWN Greenbelt		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 4-D Hillside Road 20770			
14. FATHER'S NAME FIRST Edward		MIDDLE Klem		15. MOTHER'S MAIDEN NAME Louisa						LAST Wegman	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. WW II		17. INFORMANT Virginia R. Klem Wife Same as 13		ADDRESS					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory arrest APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
DUE TO, OR AS A CONSEQUENCE OF (b) <i>Bronchitis</i>											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.											
DUE TO, OR AS A CONSEQUENCE OF (c) Multiple Sclerosis											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>Congestive heart failure</i>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE	
22a. I certify that (the hospital) attended the deceased from 4-19-86 to 4-19-86, that (we) lost saw the deceased alive on 4-16-86 and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (We) (I) did (did not) view the body after death.											
22b. SIGNATURE <i>David Schallert</i>		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 4/16/86					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>DAVID J. Schallert</i>		22e. ADDRESS 7525 Greenway Ct. Pt. #100									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Apr. 19, 1986		23c. NAME OF CEMETERY OR CREMATORIAL Gate of Heaven Cemetery Silver Spring Montgomery Md.		23d. LOCATION CITY OR TOWN		CITY OR TOWN		STATE	
24. FUNERAL DIRECTOR NAME Francis J. Collins, Jr. 500 University Blvd., W. Silver Spring, Md.		ADDRESS		25a. DATE REC'D. BY REGISTRAR APR 21 1986		25b. REGISTRAR'S SIGNATURE Julia Davidson-Henderson					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of the death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be detached from the certificate and sent in 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified.

DHMH - 16 60M 7/84
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be held within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										
1 - STATE REGISTRAR		8 REC. NO. 1 2 2 7 8								
1. DECEASED NAME (TYPE OR PRINT)		FIRST DOROTHY	MIDDLE E.	LAST KOCH	2d. DATE OF DEATH MONTH DAY YEAR				2b. HOUR 04 06 86 6 55A M	
3. SEX Female		4 RACE Caucasian	5. DATE OF BIRTH MONTH DAY YEAR August 11, 1907		6 AGE (IN YEARS LAST BIRTHDAY) 78 YRS		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE STATE OR FOREIGN COUNTRY Pennsylvania		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGES COUNTY MD.				
10. CITY OR TOWN OF DEATH CHEVERLY		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION PRINCE GEORGES GENERAL HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Clerk				12b. KIND OF BUSINESS OR INDUSTRY Woolworths		
13a. STATE Maryland		13b. COUNTY P. G.	13c. CITY OR TOWN Forestville	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 2315 Richie Road 20747				
14. FATHER'S NAME FIRST Archibald		MIDDLE 	LAST Koch	15. MOTHER'S MAIDEN NAME FIRST Carrie		MIDDLE 	LAST Shaup			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) N/A		17. INFORMANT Alice N. Hamilton		ADDRESS Same as 13 A-E				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Cerebral Vascular Accident								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last		{ DUE TO, OR AS A CONSEQUENCE OF Atherosclerotic Vascular Disease								
(b)		{ DUE TO, OR AS A CONSEQUENCE OF (c)								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 19. SIP 2 Previous Cerebral Vascular Accidents										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN	COUNTY	STATE		
22a. I certify that (in this hospital) attended the deceased from 4/1/86 to 4/6/86 , that (we) last saw the deceased alive on 4/5/86 , and that in (our) opinion death occurred on the date and hour and from the causes stated above. (We) did not view the body after death.										
22b. SIGNATURE Stuart Turkel, M.D.		DEGREE M.D.		ATTENDING PHYSICIAN <input type="checkbox"/>		MEDICAL DIRECTOR <input type="checkbox"/>	STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED 4/6/86		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Stuart Turkel, M.D.		22e. ADDRESS 7500 Greenway Center Dr. Greenbelt, Md. 20770								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 04/14/86		23c. NAME OF CEMETERY OR CREMATORIAL Trinity Memorial Garden		23d. LOCATION CITY OR TOWN Waldorf		STATE Charles Maryland		
24. FUNERAL DIRECTOR NAME Lee Funeral Home, Inc.		ADDRESS 663 Old Alexander Ferry Road Clinton, Md 20735		25a. DATE REC'D. BY REGISTRAR APR 17 1986		25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall				

00-04966

**STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

REG. NO. 12279

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM. RETAIN PAGE 4 FOR YOUR FILES. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM. RETAIN PAGE 4 FOR YOUR FILES. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM. RETAIN PAGE 4 FOR YOUR FILES. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM. RETAIN PAGE 4 FOR YOUR FILES.

TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE USED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

1 - STATE REGISTRAR

1. DECEASED NAME
(TYPE OR PRINT)FIRST
AGRA

MIDDLE

LAST

2a

DATE KNOWN
OF
ESTI-
DEATH
MATED

MONTH

DAY

YEAR

2b

HOUR

3. SEX

4. RACE

5. DATE OF BIRTH
MONTH DAY YEAR6. AGE (IN YEARS
LAST BIRTHDAY)
YRS.7. IF UNDER 1 YR.
MONTHS DAYS8. IF UNDER 24 HRS.
HOURS MIN9c. DATE
PRONOUNCED
DEAD

MONTH

DAY

YEAR

2d

2d HOUR
10:31
a.m.

Female

Caucasian

10 15 15

70

YRS.

BIRTHPLACE (STATE OR
FOREIGN COUNTRY)

Greece

7b. CITIZEN OF WHAT COUNTRY?

USA

8. MARRIED
WIDOWEDNEVER MARRIED
DIVORCED

9. BALTIMORE CITY OR COUNTY OF DEATH

Prince George

MD.

CITY OR TOWN OF DEATH

Cheverly

11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)

Prince George's General Hospital

12a. USUAL OCCUPATION (TYPE OF WORK
FOR MOST OF WORKING LIFE)

Housewife

12b. KIND OF BUSINESS
OR INDUSTRY

at home

13. RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

STATE

New Jersey

13b. COUNTY

Bergen

13c. CITY OR TOWN

Ft. Lee

13d. INSIDE CITY LIMITS?

YES NO

13e. STREET ADDRESS

421 Park Place

99999

14. FATHER'S NAME

First

Athanasios

Middle

Last

Mallis

15. MOTHER'S MAIDEN NAME

First

Middle

Unknown

Last

16a. WAS DECEASED EVER IN U.S. ARMED FORCES?

(YES, NO, OR UNKNOWN)

(IF YES, GIVE WAR ORDERS)

no

16b. SOCIAL SECURITY NO.

057-01-7596

17. INFORMANT

Nicholas Koliopoulos

ADDRESS

Upper Marlboro Md.

3213 Marcando La.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATHConditions, if any, which
gave rise to immediate
cause (a) stating the under-
lying cause lost.

DUE TO, OR AS A CONSEQUENCE OF

{ (b) DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).

MEDICAL CERTIFICATION

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?

20. AUTOPSY?

YES NO 21a. EXTERNAL CAUSE WAS
UNDERLYING OR
CONTRIBUTING CAUSE OF DEATH21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART 1 OR PART 2)

21d. INJURY OCCURRED
WHILE NOT WHILE
AT WORK AT WORK 21e. PLACE OF INJURY (AT HOME,
STREET, FACTORY, FARM, ETC.)21f. LOCATION
STREET CITY OR TOWN COUNTY STATE22a. I certify that I took charge of the remains described above, held an Autopsy , Inspection , Inquiry , and in my opinion death resulted from: Natural causes Accident , Suicide , Homicide , Undetermined manner .ACTUAL
SIGNATUREEXAMINER'S NAME
(TYPE OR PRINT)

Augusto P. Rodriguez, M.D.

TITLE (SPECIFY)
Deputy
M.D.

MEDICAL EXAMINER

DATE 4/23/1986
SIGNED23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)

Removal

23b. DATE

4/23/86

23c. NAME OF CEMETERY OR CREMATORI

George Washington

23d. LOCATION
CITY OR TOWN

Paramus

COUNTY

STATE
N.J.24. FUNERAL DIRECTOR
NAME

George P. Kalas

ADDRESS

6160 Oxon Hill Rd. Oxon Hill

25a. DATE REC'D. BY REGISTRAR

APR 28 1986

25b. REGISTRAR'S SIGNATURE

Julia Davidson-Henderson

680-1-00

10 12 15 20

white George X 1933 scarce

gold & silver 1933 scarce

gold & silver 1933 scarce

silver 1933 scarce

silver 1933 scarce
Mint of Argentina \$100.00

L.L. number 1933 scarce

gold & silver 1933 scarce

silver 1933 scarce

gold & silver 1933 scarce

00-04726

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL. ITEM 1B, GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM. RETAIN PAGES 5 FOR YOUR FILES.

TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS, AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 12280

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a DATE KNOWN OF ESTI- DEATH MATED	MONTH	DAY	YEAR	2b. HOUR	
Frank			Thomas	Koslak	<input checked="" type="checkbox"/>	4	20	86	12d HOUR		
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY) YRS.	7. IF UNDER 1 YR. MONTHS DAYS	8. IF UNDER 24 HRS. HOURS MIN	2c. DATE PRONOUNCED DEAD	MONTH	DAY	YEAR	2d. HOUR	
Male	White	Oct 19 24	61			April 20	19	86	2 AM		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's				
New Jersey		USA									
10. CITY OR TOWN OF DEATH Suitland		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 6006 Maria Avenue			12a. USUAL OCCUPATION (TYPE OF WORK) FOR MOST OF WORKING LIFE Procurement Ofc		12b. KIND OF BUSINESS OR INDUSTRY Dept Defens				
13a. STATE Maryland		13b. COUNTY Pr Geo		13c. CITY OR TOWN Suitland		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 6006 Maria Avenue 20746			
14. FATHER'S NAME Thomas		MIDDLE	Koslak		15. MOTHER'S MAIDEN NAME Frances		16. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. WWII		16c. SOCIAL SECURITY NO. 148 16 2973		17. INFORMANT Mary Koslak		ADDRESS Same as #13			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypertensive Cardio-Vascular Disease DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the <u>under-</u> <u>lying cause last.</u> (b) DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN	COUNTY	STATE			
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE Augusto P. Rodriguez		TITLE (SPECIFY) M.D. Deputy		MEDICAL EXAMINER		DATE SIGNED 4-20-86					
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS 5009 Rayburn Ct., Temple Hills, MD									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE Burial 23 April 1986	23c. NAME OF CEMETERY OR CREMATORY Resurrection Cem.		23d. LOCATION Cemetery Clinton		Maryland STATE				
24. FUNERAL DIRECTOR NAME		Robert E. Wilhelm Funeral Home ADDRESS Suitland Maryland		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE APR 24 1986 John Davidson, Jr.					
(VR A15 ME (5))											

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, then please remove carbon papers. Pages 1 and 2 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

00-02645

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8012281
REG. NO.

1 - STATE REGISTRAR

IF DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR	
			Willard	F.	Kruhm	April 2, 1986				30 2 P.M.	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)			7. IF UNDER 1 YEAR		
male		Caucasian		MONTH	DAY	YEAR	82	YRS	IF UNDER 24 HRS		
7a. BIRTHPLACE COUNTRY		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			MONTHS DAYS HOURS MIN.		
Maryland		USA		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		Prince George's Co. MD.					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)								12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	
Laurel		Greater Laurel Nursing Home								REAL ESTATE BROKER	
13. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		14. STATE		15. COUNTY		16. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS / ZIP CODE	
		MARYLAND		MONTGOMERY		BURTONSVILLE		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		3112 Winifred Drive 20866	
17. FATHER'S NAME		FIRST	MIDDLE	LAST	18. MOTHER'S MAIDEN NAME		FIRST	MIDDLE	LAST	ADDRESS	
Frederick		Wm.		KRUHM	Mary		LILLIAN		KRUHM		
19a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		19b. SOCIAL SECURITY NO.		19c. INFORMANT		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
NO		220-37-6475A		Daisy B. KRUHM - 3112 Winifred		months					
18. CAUSE OF DEATH (Enter only one cause per line for 18a, 18b, and 18c) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory arrest											
DUE TO, OR AS A CONSEQUENCE OF (b) Obstructive Hernia 3 weeks											
DUE TO, OR AS A CONSEQUENCE OF (c) Circumference of Colon 1 year											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Intestinal obstruction											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
2/28/86		Intestinal obstruction				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR AM MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
		P.M. 19									
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> WHILE AT HOME <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE	
22a. I certify that (I) (the hospital) attended the deceased from <u>February</u> , 19 <u>86</u> , to <u>April 2</u> , 19 <u>86</u> , that (I) (we) lost saw the deceased alive on <u>4/2</u> , 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated (I) (we) (did not) view the body after death.											
22b. SIGNATURE		DEGREE				22c. DATE SIGNED					
<u>Dennis R. Schuler</u>						4/2/86					
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS									
Dennis R. Schuler M.D.		1424 Laurel Park Dr #102 Laurel MD 20707									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL		23d. LOCATION		23e. DATE REC'D. BY REGISTRAR			
Burial.		Apr. 5, 1986		Union Cemetery		Burtonsville, Montg		Md.			
24. FUNERAL DIRECTOR		Takoma Funeral Home				25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
<u>X. Arthur Peters</u>		254 Carroll St. N.W.				APR 04 1986		<u>Jane Davidson Pendall</u>			

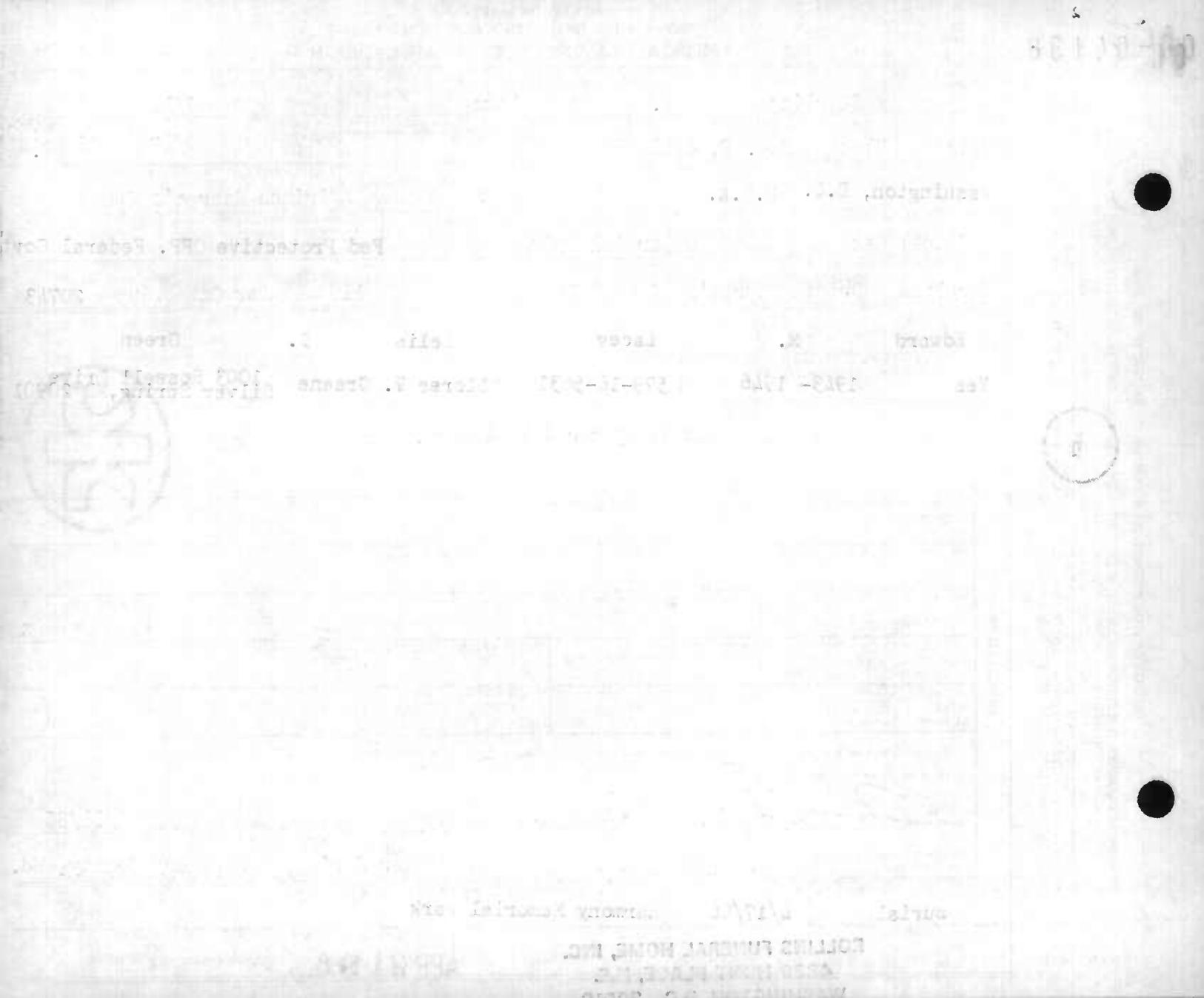
24050-00

1960-1961
1960-1961
1960-1961
1960-1961

1960-1961

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1, AND 3 TO THE FUNERAL DIRECTOR.
PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, AUGUSTA, GA.
TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRAITS PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS, AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REBURIAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO. 12282							
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE KNOWN OF ESTI- MATED				MONTH	DAY	YEAR	2b. HOUR						
Sterling			P.	Lacey		<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	4/10	19	86	M							
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY) YRS.	IF UNDER 1 YR.	IF UNDER 24 HRS.	MONTHS	DAYS	HOURS	MIN	7c. DATE PRONOUNCED DEAD			2d. HOUR						
Male	Black	Sep. 9, 1921	64							4/10	19	86	P.M.						
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED	<input type="checkbox"/>	NEVER MARRIED	<input type="checkbox"/>	WIDOWED	<input checked="" type="checkbox"/>	DIVORCED	<input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH						
Washington, D.C.		U.S.A.											Prince George's County MD						
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY									
Chapel Oak		1108 Dunbar Oak Drive				Fed Protective OFF.				Federal Govt									
13a. STATE		13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?				13e. STREET ADDRESS											
Maryland		Prince George's	Chapel Oak	YES	<input type="checkbox"/>	NO	<input type="checkbox"/>	1108 Dunbar Oak Drive 20743											
14. FATHER'S NAME FIRST		MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST				MIDDLE	LAST										
Edward		M.	Lacey	Lelia				I.	Green										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)				16b. SOCIAL SECURITY NO.				17. INFORMANT				ADDRESS							
Yes				1943-1946				Dolores V. Greene				1003 Roswell Drive Silver Spring, MD 20901							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute myocardial disease.												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause lost. (b) DUE TO, OR AS A CONSEQUENCE OF (c)																			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). None																			
19a. DATE OF OPERATION None			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?									20. AUTOPSY?							
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) None						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE													
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																			
ACTUAL SIGNATURE <i>John S. Rogers, M.D.</i>												TITLE (SPECIFY) Deputy MEDICAL EXAMINER 1919 Seminary Road ADDRESS Silver Spring, Montgomery County, Md.							
EXAMINER'S NAME (TYPE OR PRINT)			23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial									23b. DATE 4/17/86			23c. NAME OF CEMETERY OR CREMATORIAL Harmony Memorial Park			23d. LOCATION CITY OR TOWN	
24. FUNERAL DIRECTOR NAME			25a. DATE REC'D. BY REGISTRAR APR 21 1986									25b. REGISTRAR'S SIGNATURE <i>Julia Davidson Pendleton</i>							
ROLLINS FUNERAL HOME, INC. 4239 HUNT PLACE, N.E. WASHINGTON, D.C. 20011																			
DHMH - 17 (VR A15 ME (5))																			



THE GOVERNMENT OF
INDIA

THE GARDEN OF EDEN

GOA, DAMAN AND DIU

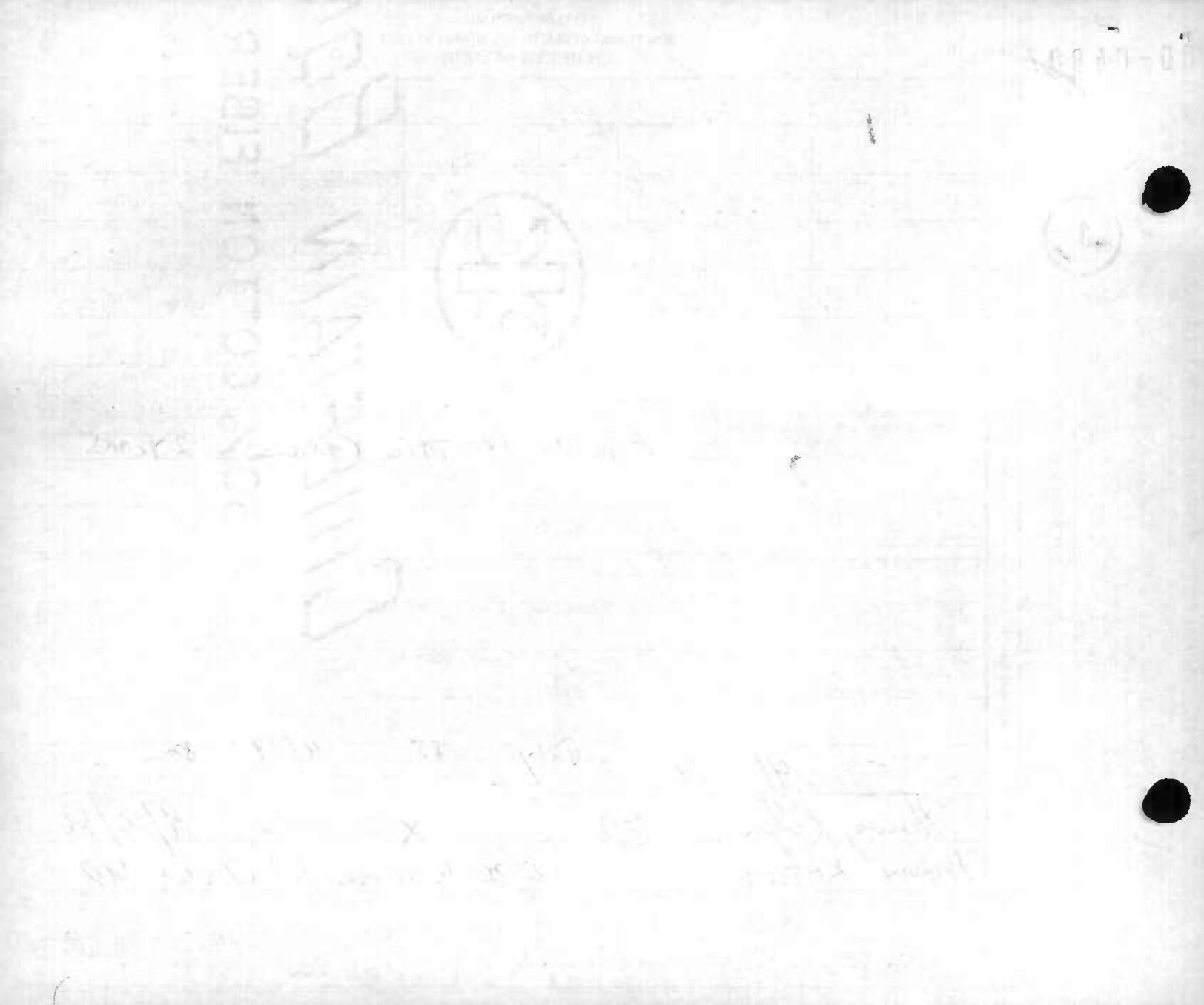
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. If page 3 is filled, attach to page 2.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be detached from the front panel permit. Then please remove carbon papers. Pages 1 and 2 should be retained by the hospital or attending physician.

IMPORTANT: If item 21 is marked as having shown any injury, or other traumatic event, the medical examiner should be notified for an examination.

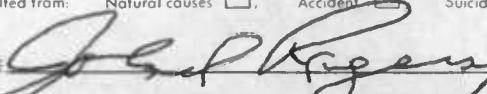
MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												
REG. NO. 8612283												
1. DECEASED NAME (TYPE OR PRINT)			FIRST HARVEY E. LANIER Sr.	MIDDLE	LAST	2a. DATE OF DEATH			MONTH APRIL	DAY 19	YEAR 1986	
3. SEX Male			4. RACE White		5. DATE OF BIRTH MONTH Oct. DAY 10 YEAR 1922		6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR MONTHS 63 DAYS YRS.		
7a. BIRTHPLACE COUNTRY North Carolina			7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGES COUNTY MD.					
10. CITY OR TOWN OF DEATH CLINTON			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SOUTHERN MD. HOSP. CTR.		12a. USUAL OCCUPATION Professional Fireman			12b. KIND OF BUSINESS OR INDUSTRY U. S. Naval Base				
13a. STATE Maryland			13b. COUNTY Pr. Geo's		13c. CITY OR TOWN Cheltenham		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE 10800 Frank Tippett Rd/20623		
14. FATHER'S NAME FIRST Cyrus			MIDDLE ---	LAST Lanier	15. MOTHER'S MAIDEN NAME FIRST Lucy			MIDDLE ---	LAST (nee Lanier)			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES OR UNKNOWN) Yes			16b. SOCIAL SECURITY NO. WWII 577-38-3400		17. INFORMANT Harvey			ADDRESS 10207 Frank Tippett Rd., E. Lanier, Jr.-Cheltenham, Md./20623				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)			Metastatic Prostate Cancer 2 YEARS									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c)									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).												
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN	COUNTY	STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>91</u> 19 86 July 19 85 to <u>4/19</u> 19 86 that (I) (we) last saw the deceased alive on <u>91</u> 19 86 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE <u>Harvey Lanier</u>			DEGREE MD									
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>HARVEY KATZEN</u>			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 4/23/86		23c. NAME OF CEMETERY OR CREMATORIAL Cheltenham Veterans Cem.			23d. LOCATION CITY OR TOWN Cheltenham (Pr. Geo's) Md.			STATE	
24. FUNERAL DIRECTOR Richard A. Coleman -Upper Marlboro, Md. 20772 Funeral Home			25a. DATE REC'D. BY REGISTRAR APR 28 1986									25b. REGISTRAR'S SIGNATURE <u>John L. Lender</u>



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B, AND TO THE FUNERAL DIRECTOR, PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM. RETAIN PAGE 5 FOR YOUR FILES.
 TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO. 12284							
1 - STATE REGISTRAR																			
1. DECEASED NAME (TYPE OR PRINT)		FIRST			MIDDLE			LAST			2a. DATE KNOWN OF ESTI- MATED		MONTH DAY YEAR	2b HOUR					
Placida		G.			Lazdauski						<input type="checkbox"/> April 4 1986		11am						
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR			6 AGE (IN YEARS) LAST BIRTHDAY		7 IF UNDER 1 YR. MONTHS DAYS		8 IF UNDER 24 HRS HOURS MIN.		2c. DATE PRONONCED DEAD		MONTH DAY YEAR	2d HOUR			
Female		White		3 13 1895			91 yrs.						<input type="checkbox"/> April 4 1986		11a				
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b CITIZEN OF WHAT COUNTRY?										8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED		9 BALTIMORE CITY OR COUNTY OF DEATH		Prince Georges Co. MD.			
Arkansas		U.S.A.																	
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)										12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b KIND OF BUSINESS OR INDUSTRY					
Riverdale		Leland Memorial Hospital										House Wife		Own Home					
13a STATE		13b COUNTY		13c CITY OR TOWN			13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS		4006 Beechwood Rd. / 20782								
Maryland		P.G. Co.		Univ. Park															
14. FATHER'S NAME FIRST		MIDDLE		LAST			15 MOTHER'S MAIDEN NAME FIRST		MIDDLE		LAST								
Joseph		-		Walston			Ursula		-		Linauskas								
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		(YES, NO, OR UNKNOWN)		16b SOCIAL SECURITY NO.			17 INFORMANT		ADDRESS										
No		None		217-34-8273			Philip P. Lazdusky (son)		Same as # 13										
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY:												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
IMMEDIATE CAUSE (a) Acute Myocardial Disease																			
DUE TO, OR AS A CONSEQUENCE OF																			
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.																			
{ (b) DUE TO, OR AS A CONSEQUENCE OF																			
(c) DUE TO, OR AS A CONSEQUENCE OF																			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)																			
Chronic Obstructive Pulmonary Disease																			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?										20 AUTOPSY?							
none												YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)														
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f LOCATION STREET CITY OR TOWN COUNTY STATE														
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																			
ACTUAL SIGNATURE 												TITLE (SPECIFY) Dep. MEDICAL EXAMINER							
EXAMINER'S NAME (TYPE OR PRINT)		John Rogers MD.										DATE SIGNED April 4, 1986							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE			23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN		23e. COUNTY		23f. STATE							
Cremation		4/5/86			Chambers Crematory			Riverdale		P.G.Co.		Md.							
24 FUNERAL DIRECTOR NAME		ADDRESS										25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
W.W. Chambers		Co. RIVERDALE, Md.										APR 10 1986		Davidson-Pandrea					
BP																			
DHMH - 17 (VR A15 ME (5))																			
20M 4/82																			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

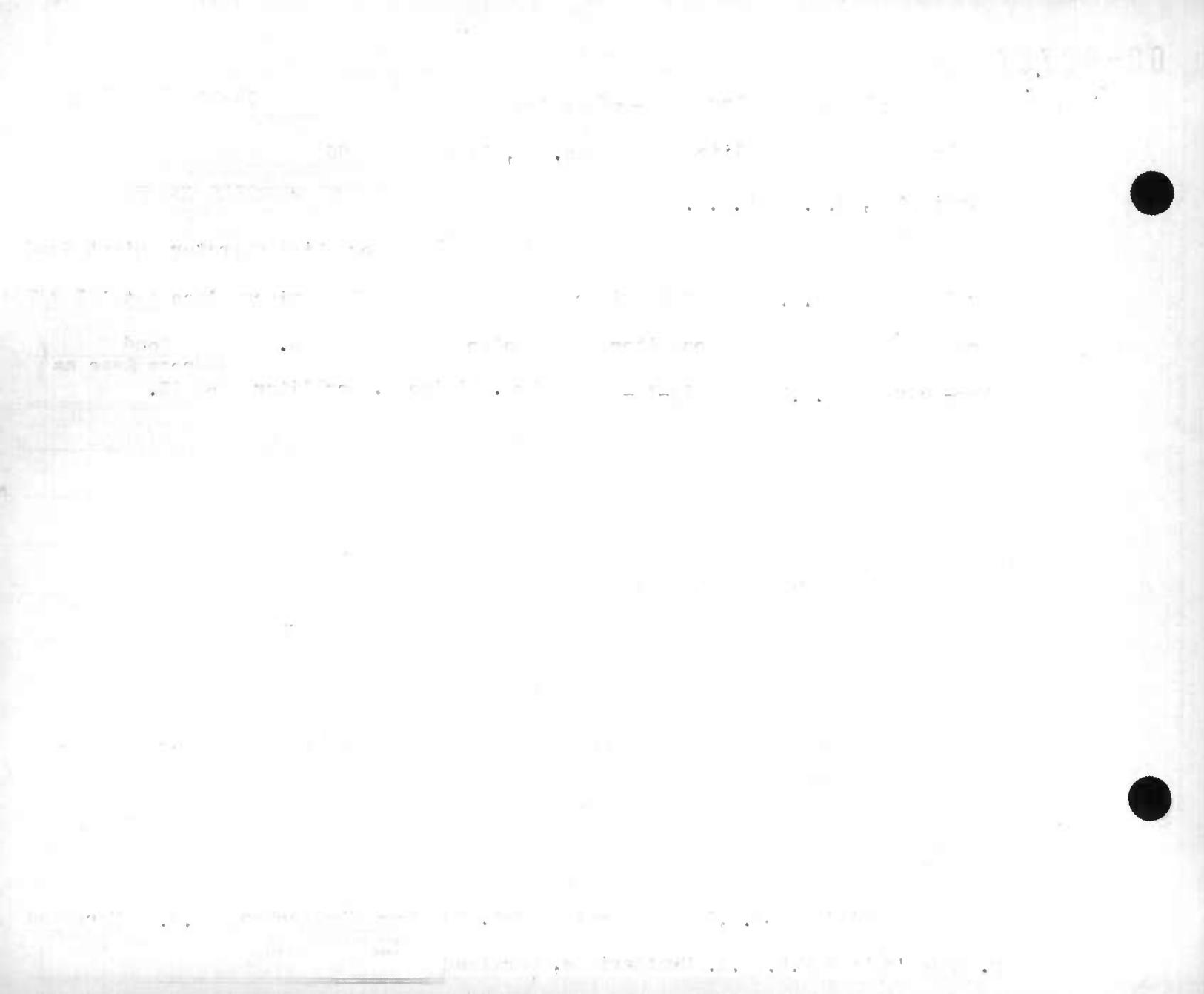
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, it should be attached for use at the burial/cremation service. Then please remove carbon paper. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death.

TO THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE: Prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked on item 18 showing any injury, or other traumatic event, the medical examiner must be notified of same.

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH8 6 | 2 2 8 5
REG. NO.

00-02787

DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	20. DATE OF DEATH	MONTH	DAY	YEAR	21. HOUR		
<i>HERMAN</i>			<i>Leo</i>	<i>LECKLITER</i>		<i>04-02-86</i>				<i>9 :15AM</i>		
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS		
Male		White		Jan. 29, 1920		66		MONTHS YRS		HOURS MIN		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH		MD.				
<i>Washington, D.C.</i>		<i>U.S.A.</i>				<i>PRINCE GEORGE'S COUNTY</i>						
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY						
<i>CHEVERLY</i>		<i>PRINCE GEORGE'S GENERAL HOSPITAL</i>		<i>Fork Lift Operator</i>		<i>Giant Food</i>						
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS				
<i>Maryland</i>		<i>P.G.</i>		<i>Hyattsville</i>		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		<i>5360 Quincy Place Apt#103 20784</i>				
14. FATHER'S NAME		FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME		FIRST	MIDDLE	LAST			
		<i>Leo</i>		<i>Lecklitter</i>			<i>Lotte</i>	<i>M.</i>	<i>Bond</i>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)		16b. SOCIAL SECURITY NO.		17. INFORMANT		18. ADDRESS		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
<i>Yes-Army</i>		<i>W.W.II</i>		<i>212-14-2746</i>		<i>Mrs. Elaine E. Lecklitter</i>		<i>Address Same as No# 13.</i>				<i>9mos</i>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>METASTATIC ADENOCARCINOMA OF COLON</i>												
DUE TO, OR AS A CONSEQUENCE OF (b) _____ (c) _____												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>DIABETES MELLITUS</i>												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?				
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE								
22a. I certify that (I) (was hospital) attended the deceased from <i>JULY 1985</i> , to <i>APRIL 2 1986</i> , that (I) (was) last saw the deceased alive on <i>APRIL 1 1986</i> , and that in (my) (was) opinion death occurred on the date and hour and from the causes stated above, (I) (was) (did) (did not) view the body after death.												
22b. SIGNATURE		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED						
<i>James A. Brown MD</i>						<i>4/2/86</i>						
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS		22f. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL		23d. LOCATION CITY OR TOWN COUNTY STATE		
<i>James A. Brown MD</i>		<i>1480 PHYSICIANS LANE, SUITE 232, ROCKVILLE, MD 20850</i>		23a. <i>Burial</i>		<i>Apr. 7, 1986</i>		<i>Maryland Vet. Cemetery Cheltenham P.G. Maryland</i>				
24. FUNERAL DIRECTOR NAME <i>F. Gasch's Sons F.H. P.A.</i>		ADDRESS <i>Hyattsville, Maryland</i>		25a. DATE FILED IN REGISTRY		25b. REGISTRAR'S SIGNATURE						
				<i>APR 7 1986</i>								



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be presented within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or if item 28 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8612286 REC. NO.				
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST		2a. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR		
BURGESS			S.		LEE		04		07	86	10 10PM	M		
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS		
MALE		BLACK		APRIL 22 1920			65			MONTHS	DAYS	HOURS	MIN.	
YRS.														
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGE'S COUNTY			MD.				
PG. MARYLAND		U.S.A.												
10. CITY OR TOWN OF DEATH CHEVERLY		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION PRINCE GEORGE'S GENERAL HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Cab Driver			12b. KIND OF BUSINESS OR INDUSTRY Self Employed							
13a. STATE MD.		13b. COUNTY P.G.		13c. CITY OR TOWN CAPT. HTS.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 6707 BLACKLOG ST. 20743						
14. FATHER'S NAME CLINTON		MIDDLE	LAST	15. MOTHER'S MAIDEN NAME MARY										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES UNKNOWN)		16b. SOCIAL SECURITY NO. WWII		17. INFORMANT AUDREY LEE 6707 BLACKLOG ST. CAPT. HTS.		ADDRESS								
YES		212-14-5433												
18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c) PART I. DEATH WAS CAUSED BY:		IMMEDIATE CAUSE (a) <u>Congestive heart failure</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
		DUE TO, OR AS A CONSEQUENCE OF (b) <u>Myocardial infarction</u>												
		DUE TO, OR AS A CONSEQUENCE OF (c) <u>Coronary artery disease</u>												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a		Diabetes Mellitus · Peripheral Vascular disease												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b PART 1 OR PART 2)		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE				
22a. I certify that (I) (this hospital) attended the deceased from <u>3-10</u> , 19 <u>86</u> , to <u>4-7</u> , 19 <u>86</u> , that (I) (we) last saw the deceased alive on <u>4/7</u> , 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.		<u>J.W.</u>										22c. DATE SIGNED <u>4/8/86</u>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) T. SURY		22e. DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/>		MEDICAL DIRECTOR <input type="checkbox"/>		STAFF PHYSICIAN <input type="checkbox"/>						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 4/11/86		23c. NAME OF CEMETERY OR CREMATORIAL Maryland Veterans Cem. Cheltenham Prince George's MD		23d. LOCATION COUNTY STATE								
24. FUNERAL DIRECTOR NAME ROLLINS FUNERAL HOME, INC. 4339 HUNT PLACE, N.E.		25a. DATE REC'D. BY REGISTRAR APR 14 1986		25b. REGISTRAR'S SIGNATURE Julia Davidson-Pandale										
WASHINGTON, D.C. 20019														

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1 2 2 8 7
REG. NO.

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1, AND 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3, RETAIN PAGE 5 FOR YOUR FILES. **TO FUNERAL DIRECTOR:** PAGE 3 SHOULD BE USED AS A BURIAL TRANSCRIPT. IT PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRATT ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

1- FOR STATE REGISTRAR		STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										2b HOUR <i>4:45</i>		
1. DECEASED NAME (TYPE OR PRINT)		FIRST			MIDDLE			LAST			2a. DATE KNOWN OF ESTI- DEATH MADE <i>April 22 1986</i>		MONTH DAY YEAR	
<i>Chic Quong Lee</i>											2c. DATE PRONOUNCED DEAD		<i>April 22 1986</i>	
3. SEX <i>M</i>		4 RACE <i>Y/O</i>		5. DATE OF BIRTH MONTH DAY YEAR		6 AGE (IN YEARS) LAST BIRTHDAY <i>23 yrs.</i>		7. IF UNDER 1 YR. MONTHS DAYS		8. IF UNDER 24 HRS. HOURS MIN		2d. DATE MONTH DAY YEAR		<i>24 HOUR 4:45</i>
10. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		11. CITIZEN OF WHAT COUNTRY?		12. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED		13. BALTIMORE CITY OR COUNTY OF DEATH		14. CITY OR TOWN OF DEATH		15. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		16. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		17b. KIND OF BUSINESS OR INDUSTRY
Baltimore, MD		United States				Riverdale Rec. Center		Riverdale Rec. Center		Auto mechanic		Prince George's Garage		Garage
13a. STATE <i>Md.</i>		13b. COUNTY <i>Prince George's Co.</i>		13c. CITY OR TOWN <i>Riverdale Rec. Center</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <i>3129 94th St., Chapt. Rd.</i>		13f. STREET ADDRESS		22822		
14. FATHER'S NAME FIRST <i>Chick</i>		MIDDLE <i>Quong</i>		LAST <i>Lee</i>		15. MOTHER'S MAIDEN NAME FIRST <i>Toshiko</i>		LAST <i>Tanaka</i>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <i>Yes</i>		16b. IF YES, GIVE WAR OR DATES <i>1981-1982</i>		16c. SOCIAL SECURITY NO. <i>578-96-3778</i>		17. INFORMANT <i>Chick Quong Lee (Father)</i>		ADDRESS <i>Lanham Hills, MD</i>						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Funeral Wound of Head</i>												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
DUE TO, OR AS A CONSEQUENCE OF { Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)														
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). <i>None</i>														
19a. DATE OF OPERATION <i>None</i>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?										20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M. 4-22 1986</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) <i>Shot self</i>		21d. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) <i>Park</i>		21e. LOCATION STREET <i>Riverdale Rec. Center</i>		CITY OR TOWN <i>Riverdale, Prince George's Co., Md.</i>		STATE		
21f. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>		21g. LOCATION STREET <i>Park</i>		21h. LOCATION STREET <i>Riverdale Rec. Center</i>		21i. LOCATION STREET <i>Riverdale Rec. Center</i>		21j. LOCATION STREET <i>Riverdale Rec. Center</i>		CITY OR TOWN <i>Riverdale, Prince George's Co., Md.</i>		STATE		
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>														
ACTUAL SIGNATURE <i>John S. Rogers, MD</i>		TITLE (SPECIFY) <i>John S. Rogers, MD</i>										DATE SIGNED <i>April 22 1986</i>		
EXAMINER'S NAME (TYPE OR PRINT)		MEDICAL EXAMINER												
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS <i>Silver Spring, Maryland</i>												
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Cremation</i>		23b. DATE <i>April 23, '86</i>		23c. NAME OF CEMETERY OR CREMATORIAL <i>Lee's Crematory</i>		23d. LOCATION CITY OR TOWN <i>Washington, District of Columbia</i>		23e. COUNTY <i>District of Columbia</i>		STATE				
24. FUNERAL DIRECTOR NAME <i>J.W. Lee's Sons Co., 300-4th St., NE, Wash., DC 20002</i>		ADDRESS		25a. DATE REC'D. BY REGISTRAR <i>APR 28 1986</i>		25b. REGISTRAR'S SIGNATURE <i>John Davidson, Registrar</i>								
DMMH - 17 (VR A15 ME (5))														

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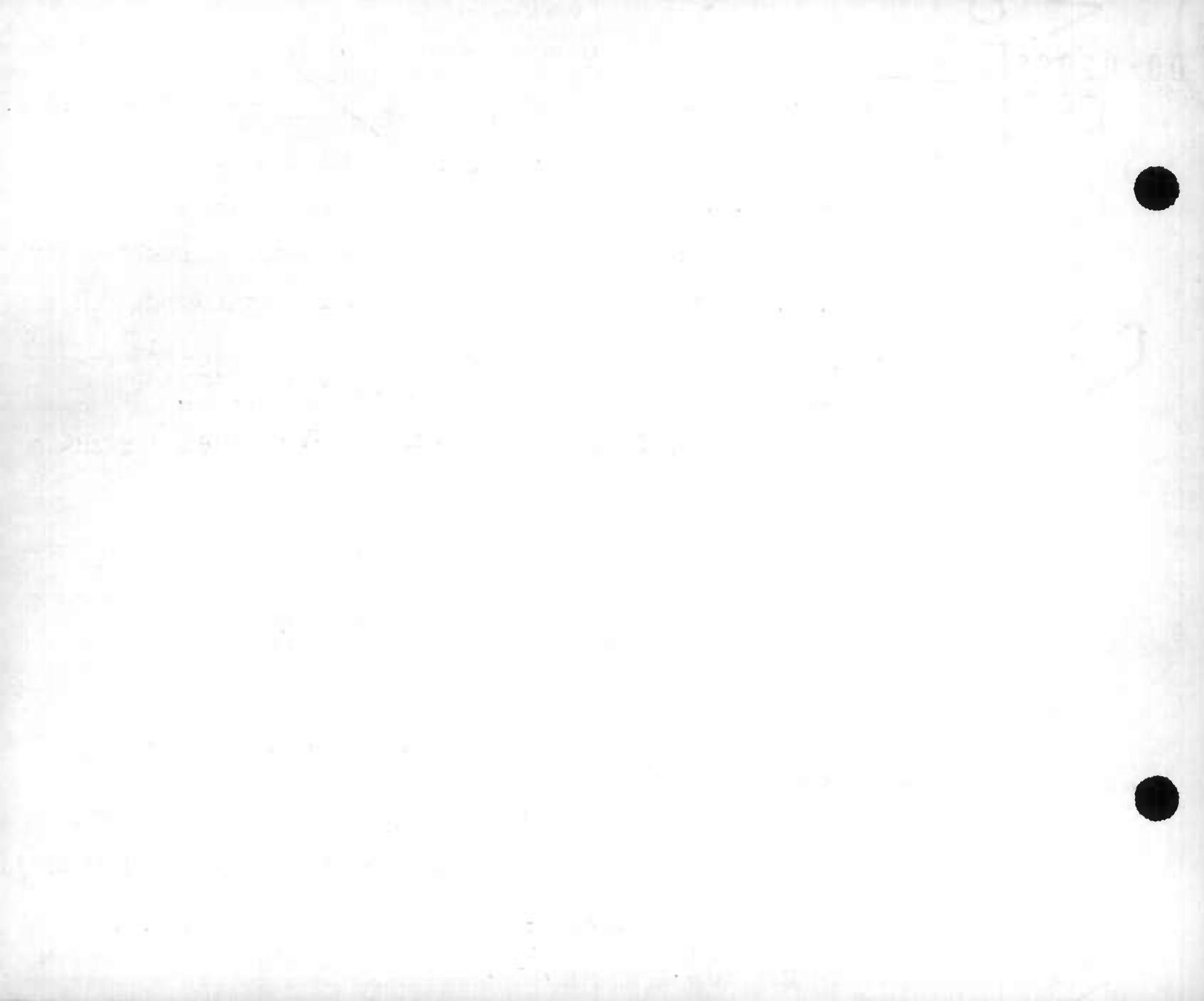
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be referred by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the Burial/Transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 12288					
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE			LAST			2a. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR	
CLYDE A.						LEGO			4-3-86				11:35 P.M.		
3. SEX Male			4. RACE White			5. DATE OF BIRTH MONTH DAY YEAR Feb. 15, 1929			6. AGE (IN YEARS LAST BIRTHDAY) 57		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Prince Georges		MD.				
10. CITY OR TOWN OF DEATH Lanham			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 6313 Barr's Lane			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Manager			12b. KIND OF BUSINESS OR INDUSTRY Cooks Meats						
13a. STATE Maryland			13b. COUNTY P. G.			13c. CITY OR TOWN Lanham			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 6313 Barrs Lane 20801				
14. FATHER'S NAME FIRST James			MIDDLE Lego			15. MOTHER'S MAIDEN NAME FIRST Minnie			MIDDLE Nale						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes			16b. SOCIAL SECURITY NO. Korean 174-24-3908			17. INFORMANT Shirley Lego			ADDRESS 6313 Barrs Lane Lanham, Md. 20706						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) BRAIN TUMOR (GLIOBLASTOMA)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 year					
DUE TO, OR AS A CONSEQUENCE OF (b) _____ (c) _____															
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)															
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)									
21d. INJURY OCCURRED NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that (I) (this hospital) attended the deceased from MAY 19, 85 to April 19, 1986 , that (we) lost the deceased alive on MID MARCH 19, 86 , and that in (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.															
22b. SIGNATURE Robert Gerwin										DEGREE MD	ATTENDING PHYSICIAN <input checked="" type="checkbox"/>	MEDICAL DIRECTOR <input type="checkbox"/>	STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED 4/4/86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Robert Gerwin MD			22e. ADDRESS 7500 Hanover Pkwy, Greenbelt Md 20770												
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation			23b. DATE 4/7/86			23c. NAME OF CEMETERY OR CREMATORIAL Lees Crematory			23d. LOCATION CITY OR TOWN Washington, D.C.		COUNTY	STATE			
24. FUNERAL DIRECTOR NAME Rendon/Hale Lanham Funeral Home 9013 Annapolis Rd. Lanham, Md.									25a. DATE REC'D. BY REGISTRAR APR 08 1986		25b. REGISTRAR'S SIGNATURE J. Rendon Hale				



00-04165

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FOR STATE 5/26/86 rja
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH8 6 1 2 2 8 9
REG. NO.

DECEASED NAME (TYPE OR PRINT)			FIRST Angie	MIDDLE Rhodes	LAST Rose LINDAHL	2a DATE OF DEATH April 16, 1986	MONTH APRIL	DAY 16	YEAR 1986	2b HOUR 3:02a.m.	
3. SEX Female			4. RACE White		5. DATE OF BIRTH MONTH July DAY 20 , YEAR 1920	6 AGE (IN YEARS LAST BIRTHDAY) 65		IF UNDER 1 YEAR MONTHS YRS.		IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Alabama			7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's County, MD.					
10. CITY OR TOWN OF DEATH Lanham			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) AMI/Doctors' Hospital of PG County		12a. USUAL OCCUPATION Cafeteria Manager School		12b. KIND OF BUSINESS OR INDUSTRY				
13a. STATE Maryland			13b. COUNTY P.G. Co.	13c. CITY OR TOWN Glenn Dale	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS 12508 Sir Walter Drive / 20769					
14. FATHER'S NAME FIRST John			MIDDLE T.	LAST Rhodes	15. MOTHER'S MAIDEN NAME FIRST Angie	MIDDLE K.	LAST Brannon				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) None		17. INFORMANT Ivan L. Lindahl (Husband)	ADDRESS Same as # 13.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory failure, liver failure								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
DUE TO, OR AS A CONSEQUENCE OF (b) pleural effusions, pneumonia											
DUE TO, OR AS A CONSEQUENCE OF (c) lung and pleural cancer with liver metastases											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Cardiac arrhythmia, congestive heart failure, sepsis, renal insufficiency											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that <input type="checkbox"/> (this hospital) attended the deceased from 1976 , 19 86 , to 4/16 , 19 86 , that <input type="checkbox"/> (we) last saw the deceased alive on 4/15 , 19 82 , and that in <input type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input type="checkbox"/> (we) did <input checked="" type="checkbox"/> (did) <input type="checkbox"/> (did not) view the body after death.											
22b. SIGNATURE Jill Karatinos, M.D.			22c. DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22d. DATE SIGNED 4/16/88				
22e. PHYSICIAN'S NAME (TYPE OR PRINT) Jill Karatinos, M.D.			22f. ADDRESS 14300 Gilbert Fox Ln 5k 202 Bowie, Md. 20715								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE April/19/86	23c. NAME OF CEMETERY OR CREMATORIAL Ft. Lincoln Cemetery		23d. LOCATION CITY OR TOWN Brentwood, P.G. Co., Maryland		23e. COUNTY STATE			
24. FUNERAL DIRECTOR NAME Chambers Funeral Home Riverdale, Maryland			ADDRESS		25a. DATE REC'D. BY REGISTRAR APR 21 1986		25b. REGISTRAR'S SIGNATURE Julie Davidson-Randall				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 18 is marked or Item 21 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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FOR Film G615 item 18/22a
1- STATE 5/27/86 rjaSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1 2 2 9 0

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF A DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM W.J. 100-1000000-15 FOR YOUR FILES. PAGE 4 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE KEPT WITHIN 72 HOURS AFTER DEATH WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

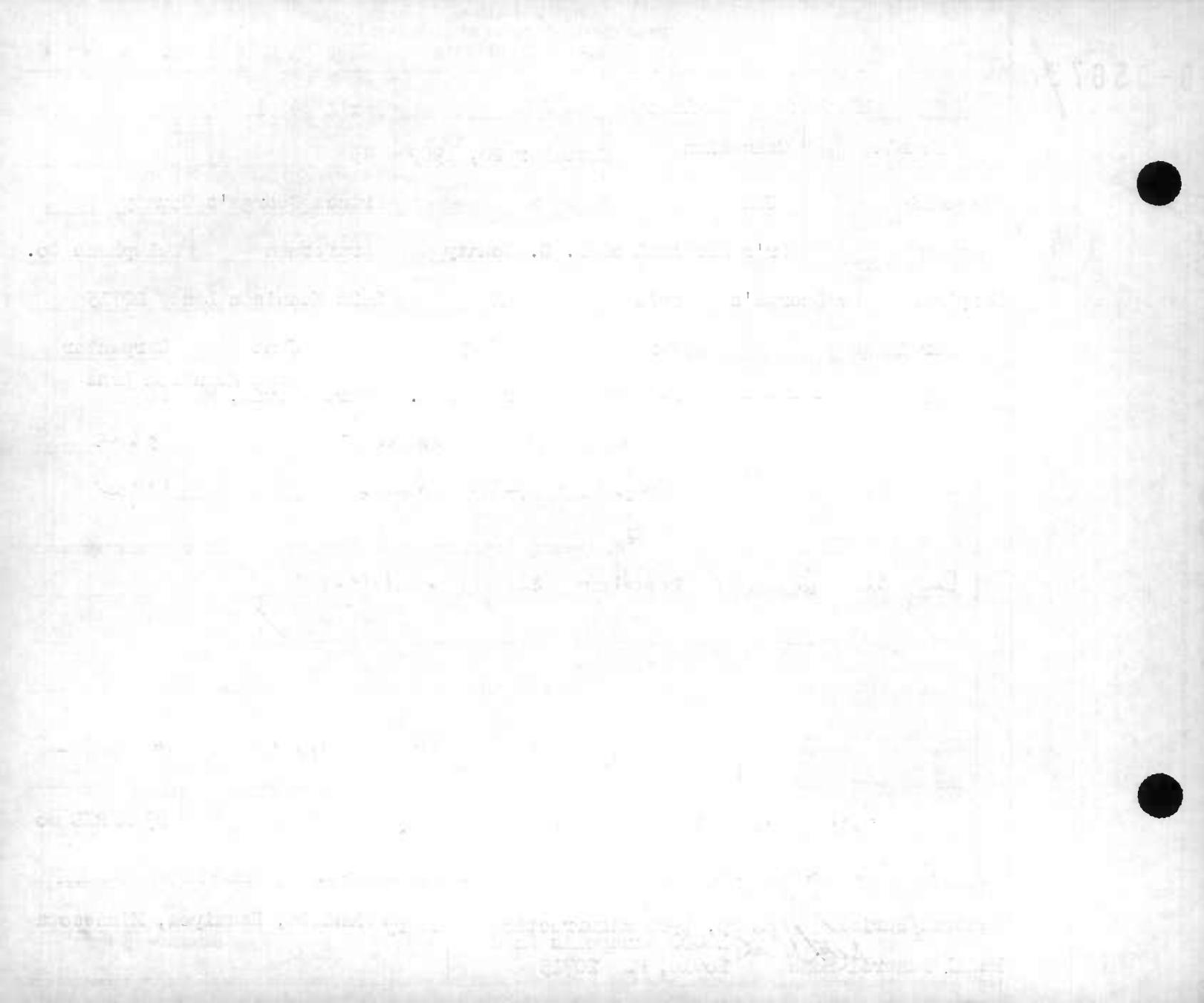
1. DECEASED NAME (TYPE OR PRINT)		FIRST	MIDDLE	LAST	2a. DATE KNOWN OF ESTI- MATED	MONTH	DAY	YEAR	2b. HOUR M	
		STEVE		LINDSAY	<input checked="" type="checkbox"/>	4	15	1986		
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	7. IF UNDER 1 YR. MONTHS DAYS	8. IF UNDER 24 HRS. HOURS MIN.					
Male	Black	08 12 1956	29 yrs.							
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH				
Dist. of Columbia		U.S. A.				Prince George's County				
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY				
Cheverly		Prince George's General Hosp.		Laborer		Construction				
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS					
DC		Washington	342 Ridge Rd., S.E.							
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST								
Robert		Lindsay		Doris Ellis						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS				
		577-76-7785		Darlene William		251 58th St., N.E. #31				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Conditions, if any, which gave rise to immediate cause (a) stating the <u>under-</u> <u>lying cause last.</u> (b) (c) DUE TO, OR AS A CONSEQUENCE OF										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?						
				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>						
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 4/15 19 86		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) Subject injected drug						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) Home		21f. LOCATION STREET 7625 Oxman Rd.		CITY OR TOWN Landover		COUNTY Prince George's		STATE Maryland
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/>										
ACTUAL SIGNATURE										TITLE (SPECIFY) M.D. Assistant MEDICAL EXAMINER
EXAMINER'S NAME (TYPE OR PRINT)		Ann M. Dixon, M.D.		ADDRESS 111 Penn St., Balto., MD 21201						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE Burial 4-22-86		23c. NAME OF CEMETERY OR CREMATORIAL Harmony Mem. Park		23d. LOCATION CITY OR TOWN Landover		COUNTY PG		STATE MD
24. FUNERAL DIRECTOR NAME		ADDRESS Robert G. Mason 1661 Good Hope Rd. S.E.		25a. DATE REC'D. BY REGISTRAR APR 28 1986		25b. REGISTRAR'S SIGNATURE Julia Davidson-Jandera				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, file funeral director, page 3
 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
 IMPORTANT: If item 21 is marked underlying, it shows any injury or other traumatic event, the medical examiner will be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO. 12291	
1 - STATE REGISTRAR			1 DECEASED NAME (TYPE OR PRINT)			FIRSl MIDDLE LAST			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR	
Elizabeth Adeliade LUKACH									April 24, 1986			12:17PM	
3. SEX Female		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR November 20, 1909			6. AGE (IN YEARS LAST BIRTHDAY) 75 YRS			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Wisconsin		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's County			MD.			
10. CITY OR TOWN OF DEATH Lanham		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Dr's Hospital of P. G. County			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Draftsman			12b. KIND OF BUSINESS OR INDUSTRY Telephone Co.					
13a. STATE Maryland		13b. COUNTY Pr George's		13c. CITY OR TOWN Bowie		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 2626 Kennison Lane 20715					
14. FATHER'S NAME FIRST Ferdinand		MIDDLE Rivard		LAST		15. MOTHER'S MAIDEN NAME FIRST Mary		MIDDLE Jane			LAST Carpenter		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO 468-01-5208		17. INFORMANT Marybeth A. Rogers		ADDRESS 2626 Kennison Lane Bowie, MD 20715							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 hrs.											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		DUE TO, OR AS A CONSEQUENCE OF (b) <u>Cerebral Stroke</u> (c) <u>Stroke</u>											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>Congestive Heart Disease; Infective Endocarditis; Hypertension</u>													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> V			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY	STATE		
22a. I certify that (I) (we) hospital attended the deceased from <u>4/20</u> , 19 <u>86</u> , to <u>4/24</u> , 19 <u>86</u> , that (I) (we) last saw the deceased alive on <u>4/24</u> , 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE <u>Jack C. Meshel</u>		22c. DEGREE MD			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22d. DATE SIGNED 25 APRIL 86					
22e. ADDRESS 5806 Baltimore Ave., Hyattsville, Md. 20781													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Removal/Burial		23b. DATE APR. 20, 1986			23c. NAME OF CEMETERY OR CREMATORIAL Resurrection Cemetery			23d. LOCATION CITY OR TOWN Mendota, Hennipen, Minnesota					
24. FUNERAL DIRECTOR NAME Beall Funeral Home		ADDRESS 16000 Annapolis Road Bowie, MD 20715			25a. DATE REC'D. BY REGISTRAR MAY 6 1986			COUNTY STATE					

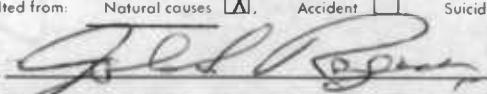


TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE WRITING THE WORD "PENDING" IN PENCIL IN ITEMS 1B, 2, AND 3 TO THE FUNERAL DIRECTOR.

ITEM 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONE, WITH FAX MAILED. WITH FAX MAILED, ITEM 5 FOR YOUR FILES.

TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. DATES 1 AND 2 SHOULD BE FILLED. WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET,

BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO. 2292		
1- STATE REGISTRAR			2a. DATE KNOWN OF ESTI- DEATH MATED <input checked="" type="checkbox"/> 4/22 1986									2b. HOUR 6:45		
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2c. DATE PRONOUNCED DEAD 4/22 1986			2d. HOUR 6:45					
Margaret Black Lynch														
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN				
Female		White		Sep. 10, 1898		87 yrs.								
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's County MD.								
Penns.		U.S.A.												
11. CITY OR TOWN OF DEATH Hyattsville		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS 5612 Randolph Street						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife			12b. KIND OF BUSINESS OR INDUSTRY Own Home			
13a. STATE Washington, D. C.		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 4801 Connecticut Avenue, N. W.						
14. FATHER'S NAME William		MIDDLE		LAST Black		15. MOTHER'S MAIDEN NAME unavailable					LAST			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) yes		(IF YES, GIVE WAR OR DATES) WW 11		16b. SOCIAL SECURITY NO. 578-62-3884		17. INFORMANT Robert E. Lynch (Husband)		ADDRESS same as # 13						
18. CAUSE OF DEATH (Enter only one cause per line for (o), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) Acute myocardial disease												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
DUE TO, OR AS A CONSEQUENCE OF (b) chronic myocardial disease.														
DUE TO, OR AS A CONSEQUENCE OF (c)														
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (o) Alzheimer's disease														
19a. DATE OF OPERATION None			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) None								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN	COUNTY	STATE			
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>														
ACTUAL SIGNATURE 			TITLE (SPECIFY) M.D. Deputy MEDICAL EXAMINER 1919 Seminary Road Silver Spring, Montgomery County, Md.						DATE SIGNED 4/22/86					
EXAMINER'S NAME (TYPE OR PRINT) John S. Rogers, M.D.			23a. BURIAL, CREMATION, REMOVAL 1 SPECIFY Burial						23b. DATE Apr. 24, 1986		23c. NAME OF CEMETERY OR CREMATORIUM Mt. Olivet Cemetery		23d. LOCATION CITY OR TOWN Washington, D.C.	
24. FUNERAL DIRECTOR NAME John F. DeVoe			25a. DATE REC'D. BY REGISTRAR APR 29 1986						25b. REGISTRAR'S SIGNATURE 					
DeVoe Funeral Home														
DHMH - 17 (VR A15 ME (5))														

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1947 (1947) 100-1000



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LIBRARY OF CONGRESS
JULY 1947

1947 (1947) 100-1000

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached from this burial permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Death and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as Item 13B shows any injury, air other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

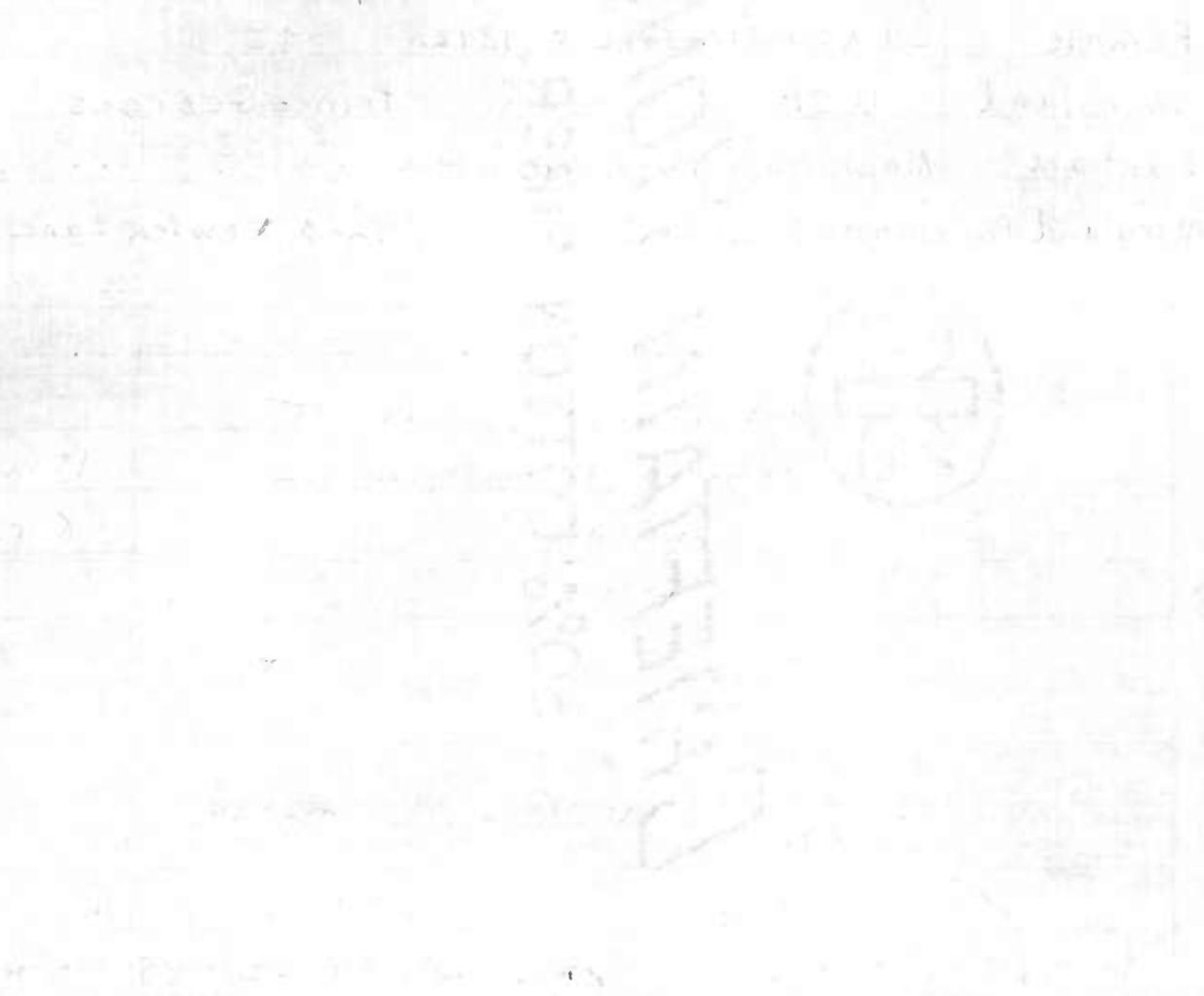
STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 6 1 2 2 9 3						
										REG. NO.						
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	20. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR				
Minnie Seuberlich Lynn						April 22, 1986						1150 P.M.				
3. SEX			4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS				
Female			Caucasian		June 8, 1892		93			MONTHS	DAYS	HOURS	MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?		8		9			9 BALTIMORE CITY OR COUNTY OF DEATH						
Maryland			USA		MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		93			Prince Georges						
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			MD.						
Lanham			Magnolia Gardens Nursing Home		Ret. Dietary		P.G. Hospital			20801						
13a. STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?			13e. STREET ADDRESS / ZIP CODE						
Maryland			Prince Georges		Lanham		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			9220 Fowler Lane						
14. FATHER'S NAME			MIDDLE	LAST	15. MOTHER'S MAIDEN NAME		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (LIVES, NO OR UNKNOWN)			17. INFORMANT		ADDRESS				
Charles				Seuberlich	Katherine		No			Mildred E. Clatterbaugh		9218 Fowler Lane Lanham, Md. 20706				
18. CAUSE OF DEATH (Enter only one cause per line for 1a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH													
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			15 yrs													
(b) _____			15 yrs													
(c) _____			8 yrs.													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a																
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?					
								YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)		21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN	COUNTY	STATE
22a. I certify that (I) (this hospital) attended the deceased from 1-23-86, 19, to 4-23-86, 19, that (I) (we) lost saw the deceased alive on 4-23-86, 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.																
22b. SIGNATURE			DEGREE											22c. DATE SIGNED		
Andres C. Lara														APR 28 1986		
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>													
Andres C. Lara			22e. ADDRESS 9326 Lanham Severn Rd. Lanham, Md. 20706													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN		CITY OR TOWN		COUNTY		STATE		
Burial			4/25/86		Fort Lincoln Cemetery			Brentwood		P.G.		Maryland				
24. FUNERAL DIRECTOR			25a. DATE REC'D. BY REGISTRAR											25b. REGISTRAR'S SIGNATURE		
Francis Gasch's Sons Funeral Home, P.A.			APR 28 1986											Julie Swanson-Pender		
4739 Baltimore Avenue Hyattsville, Md. 20781																

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the physician be renoted by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the physician it should be detached for use as the burial/transit permit. Then please return it to the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
8 6 1 2 2 9 4 REG. NO.											
1. DECEASED NAME (TYPE OR PRINT)			FIRST <i>Hyman</i>	MIDDLE <i></i>	LAST <i>Mallach</i>	2a DATE OF DEATH <i>APRIL 4, 1986</i>	MONTH <i>APRIL</i>	DAY <i>4</i>	YEAR <i>1986</i>	2b HOUR <i>5:00 P.M.</i>	
3. SEX MALE			4. RACE WHITE	5. DATE OF BIRTH <i>APRIL 16, 1922</i>			6. AGE (IN YEARS LAST BIRTHDAY) 63 YRS.			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a BIRTHPLACE NEW YORK			7b CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGE'S COUNTY		
10. CITY OR TOWN OF DEATH BOWIE			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION 12418 STRETTON LANE			12a USUAL OCCUPATION SALESMAN			12b KIND OF BUSINESS OR INDUSTRY INDUSTRIAL		
13a STATE MARYLAND			13b COUNTY PRINCE GEORGES			13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e STREET ADDRESS / ZIP CODE 20715 12418 STRETTON LANE		
14. FATHER'S NAME JACOB			15. MOTHER'S MAIDEN NAME SARAH								
16a WAS DECEASED EVER IN U.S. ARMED FORCES? YES			16b. SOCIAL SECURITY NO. 067-16-7269			17. INFORMANT MARK MALLACH, 815 RUXSHIRE DRIVE ARNOLD, MARYLAND			ADDRESS		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiogastroenteric Arrest</i>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			(b) <i>Gastric (cardiac) cramping</i>								
(c)			DUE TO, OR AS A CONSEQUENCE OF								
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK			21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f LOCATION STREET CITY OR TOWN COUNTY STATE					
22a I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <i>D. Stein</i>			22c. DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22d. DATE SIGNED <i>4/13/86</i>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Donald M. Stein</i>			22e. ADDRESS <i>3231 Superior Lane Bowie MD</i>								
23a BURIAL, CREMATION, REMOVAL BURIAL			23b. DATE 4/4/1986			23c NAME OF CEMETERY OR CREMATORY KNESSETH ISRAEL CEMETERY ANNAPOLIS			23d. LOCATION CITY OR TOWN ANNAPOLIS		
24. FUNERAL DIRECTOR DONALD M. STEIN HEBREW MEMORIAL FUNERAL HOME 232 CARROLL STREET, N. W., WASHINGTON, D. C.						25a. DATE REC'D. BY REGISTRAR APR 9 1986			25b. REGISTRAR'S SIGNATURE <i>John J. Dawson</i>		

43188-00



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page # may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be retained by the funeral director with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as Item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												
REG. NO. 12295												
1. FOR STATE REGISTRAR			DECEASED NAME FIRST PAULINE G. MATCHETT MIDDLE			LAST			2a DATE OF DEATH MONTH 04 DAY 14 YEAR 86		2b. HOUR 9:15 Pm	
DECEASED NAME (TYPE OR PRINT)												
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH Jan. DAY 27 YEAR 1918			6. AGE (IN YEARS LAST BIRTHDAY) 68		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) West Virginia		7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGE M.D.				
10. CITY OR TOWN OF DEATH CLINTON		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Southern md Hospital						12a. USUAL OCCUPATION Clerk		12b. KIND OF BUSINESS OR INDUSTRY Peoples Drug		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)												
13a. STATE Maryland		13b. COUNTY P.G.		13c. CITY OR TOWN New Carrollton			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 7845 Riverdale Road, Apt. #101		20 784	
14. FATHER'S NAME FIRST Charles MIDDLE W. LAST Penwell					15. MOTHER'S MAIDEN NAME FIRST Virgil MIDDLE Virginia LAST Smallwood							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (IF NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 579-22-7917			17. INFORMANT William Matchett (Husband) Same as #13			ADDRESS				
18. CAUSE OF DEATH Enter only one cause per line for 1a, 1b, and 1c. PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive Heart Failure APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH												
DUE TO OR AS A CONSEQUENCE OF (b) Arteriosclerotic Heart Disease												
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) DUE TO OR AS A CONSEQUENCE OF (c)												
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) Cardiac Arrest - Ischemic												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from 4/16/86 to 4/17/86, that (I) (we) last saw the deceased alive on 4/14/86 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE		22c. DEGREE			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22d. DATE SIGNED 4/15/86				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) REED MOSTBURN		22e. ADDRESS 4235 38th Ave. Md. 20748						Temple Hills,				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 04/15/86		23c. NAME OF CEMETERY OR CREMATORIUM Fort Lincoln Cemetery			23d. LOCATION CITY OR TOWN Brentwood		CITY OR TOWN P.G.		STATE Maryland	
24. FUNERAL DIRECTOR'S NAME Francis Gasch's Sons Funeral Home, P.A.		ADDRESS 4739 Baltimore Avenue Hyattsville, Md. 20781			25a. DATE REC'D. BY REGISTRAR APR 21 1986			25b. REGISTRAR'S SIGNATURE Julia Davidson				

8-136 242-85

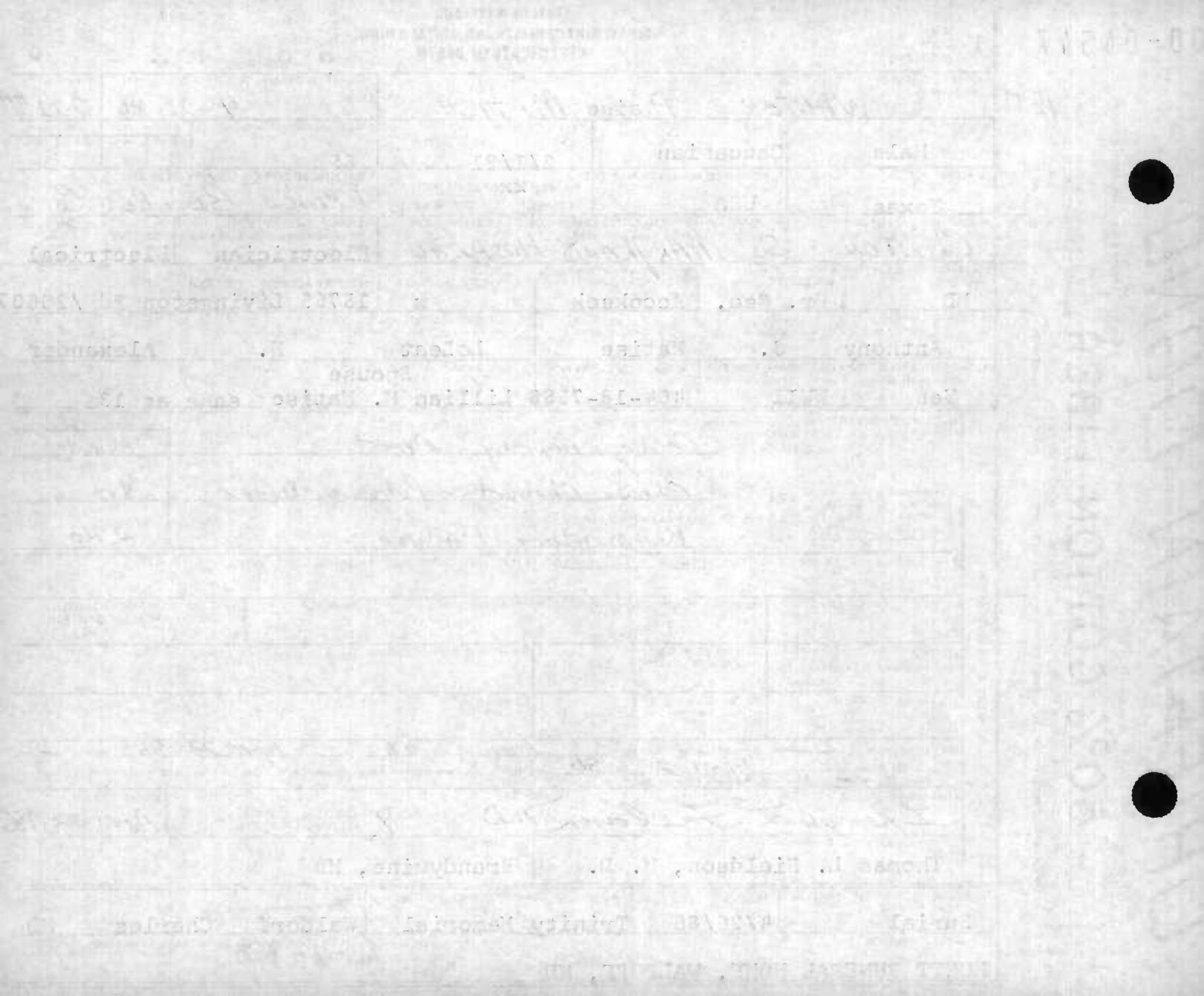
80318876

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

(IMPORTANT: If item 21 is marked as Item 18 showing injury, or other traumatic event, the medical examiner must be notified at once.)

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO. 8012296	
1 - STATE REGISTRAR				2d. DATE OF DEATH MONTH DAY YEAR 4-22-86								2b. HOUR 7:22 AM	
1. DECEASED NAME (TYPE OR PRINT) <i>WALTER P. Paige MATISE</i>				2d. DATE OF DEATH MONTH DAY YEAR 4-22-86				2b. HOUR 7:22 AM					
3. SEX Male		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR 2/1/21			6. AGE (IN YEARS LAST BIRTHDAY) 65 YRS			IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Texas		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Prince Georges Co MD.						
10. CITY OR TOWN OF DEATH Clinton		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) So. Maryland Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Electrician			12b. KIND OF BUSINESS OR INDUSTRY Electrical						
13a. STATE MD		13b. COUNTY Pr. Geo.		13c. CITY OR TOWN Accokeek			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE 15755 Livingston Rd / 20607			
14. FATHER'S NAME FIRST Anthony		MIDDLE J.		LAST Matise			15. MOTHER'S MAIDEN NAME FIRST LoLeat			MIDDLE N.		LAST Alexander	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. WWII		16c. INFORMANT Spouse			16d. ADDRESS Lillian M. Matise same as 13			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Minutes			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiopulmonary Arrest</i>													
DUE TO, OR AS A CONSEQUENCE OF (b) <i>Chronic Obstructive Pulmonary Disease</i> Yrs													
DUE TO, OR AS A CONSEQUENCE OF (c) <i>Respiratory Failure</i> 2 mo													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. 19a. DATE OF OPERATION													
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED													
20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>													
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that (I) <input type="checkbox"/> hospital attended the deceased from May 19, 1986, to April 22, 1986, that (I) <input type="checkbox"/> saw the deceased alive on April 21, 1986, and that in (my) <input type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above. (I) <input type="checkbox"/> did (did not) view the body after death.													
22b. SIGNATURE <i>Thomas L. Fieldson MD</i>		22c. DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22d. DATE SIGNED April 22, 1986						
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Thomas L. Fieldson, M. D.		22e. ADDRESS Brandywine, MD											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 4/26/86		23c. NAME OF CEMETERY OR CREMATORIAL Trinity Memorial			23d. LOCATION CITY OR TOWN Waldorf			COUNTY Charles		STATE MD	
24. FUNERAL DIRECTOR NAME HUNTT FUNERAL HOME, WALDORF, MD		ADDRESS		25a. DATE REC'D. BY REGISTRAR APR 24 1986			25b. REGISTRAR'S SIGNATURE						



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE WRITING THE WORD "PENDING" IN PENCIL IN BOX 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FOR HIM TO RETAIN. YOUR FILES TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSFER REPORT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO. 2291				
1. DECEASED NAME (TYPE OR PRINT)			FIRST			MIDDLE			LAST			2a. DATE KNOWN OF ESTI- DEATH MATED	MONTH	DAY	YEAR	2b. HOUR
VENETTA			LYNETTE			MATTHEWS						<input checked="" type="checkbox"/> APR 18	19	86	M	
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	7. IF UNDER 1 YR.	8. IF UNDER 24 HRS.	MONTHS	DAYS	HOURS	MIN	2c. DATE PRONOUNCED DEAD	MONTH	DAY	YEAR	2d. HOUR 6:30 a.m.		
Female	BLACK	9-18-76	9 yrs.							<input checked="" type="checkbox"/> APR 18	19	86				
7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH							
MARYLAND			UNITED STATES			WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			PRINCE GEORGE							
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY							
Suitland			4644 Suitland Lane			STUDENT			PRIVATE							
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS				
MARYLAND			PRINCE GEORGE			SUITLAND						4864 Eastern Lane / 20746				
14. FATHER'S NAME FIRST			MIDDLE			LAST			15. MOTHER'S MAIDEN NAME FIRST			LAST				
ARTHEROL						HUDNELL			IRIS			MATTHEWS				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			4864 ADDRESS			Eastern Lane				
NO			220-72-9698			Iris Hudnell			Suitland, Maryland							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY:																
IMMEDIATE CAUSE (a) <u>Microcephaly with seizure disorder</u>																
DUE TO, OR AS A CONSEQUENCE OF																
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.																
(b)																
DUE TO, OR AS A CONSEQUENCE OF																
(c)																
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (b).																
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY?										
									YES <input type="checkbox"/>			NO <input checked="" type="checkbox"/>				
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)										
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY STATE				
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>																
ACTUAL SIGNATURE <i>Augusto P. Rodriguez</i>			TITLE (SPECIFY) M.D. Deputy			MEDICAL EXAMINER			DATE SIGNED 4/18/1986							
EXAMINER'S NAME (TYPE OR PRINT)			ADDRESS			5009 Rayburn CT, Temple Hills, Md										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN			COUNTY		STATE		
BURIAL			4-21-86			HARMONY MEMORIAL			HYATTSVILLE P.G.			MD.				
24. FUNERAL DIRECTOR NAME			ADDRESS			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE							
THORNTON FUNERAL HOME POMONKEY, MD.																
APR 23 1986 <i>Julie L. Jordan-Pender</i>																

01810-7



death: Page 4 may be

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the state Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or if item 18 shows any injury, or after a traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												80012298		
												REG. NO.		
1. FOR STATE REGISTRAR			I. DECEASED NAME (TYPE OR PRINT)			LAST			2d DATE OF DEATH			2d. HOUR		
			Mae			McClellan			4-5-86			8:30 P.M.		
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)					
F			Negro			MONTH DAY YEAR			70			IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			Prince George's Co. MD		
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY					
Laurel			Greater Laurel Nursing Home			n/a						21215		
13a. STATE Md			13b. COUNTY Baltimore			13c. CITY OR TOWN Baltimore			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS 1922 Fairmount Ave		
14. FATHER'S NAME FIRST Abraham			MIDDLE Golden			15. MOTHER'S MAIDEN NAME FIRST Fannie			MIDDLE Jones			LAST		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO			16b. SOCIAL SECURITY NO. 214 20 6798			17. INFORMANT Linda McClellan 15434 Arboryway Laurel			ADDRESS			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Respiratory arrest DUE TO, OR AS A CONSEQUENCE OF (b) Diabetes Mellitus DUE TO, OR AS A CONSEQUENCE OF (c)														
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a Status post Cerebrovascular Accident														
19a. MEDICAL CERTIFICATION DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE								
22a. I certify that <input type="checkbox"/> (this hospital) attended the deceased from <u>3/21</u> 19 <u>85</u> to <u>7/5</u> 19 <u>86</u> , that <input type="checkbox"/> (we) last saw the deceased alive on <u>19 86</u> and that in my <input type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input type="checkbox"/> (We did) did not view the body after death.														
22b. SIGNATURE <i>John Margolis</i>			DEGREE <i>MD</i>			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED <i>4/5/86</i>					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>John Margolis</i>			22e. ADDRESS <i>14333 Laurel Ave, Laurel, MD 20708</i>											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE 3-10-86			23c. NAME OF CEMETERY OR CREMATORIAL CEDAR HILL			23d. LOCATION CITY OR TOWN ANNE ARUNDEL			STATE MARYLAND		
24. FUNERAL DIRECTOR NAME WM. C. MARCH F/H INC.			ADDRESS 1101 E. NORTH AVE.			25a. DATE REC'D. BY REGISTRAR APR 09 1986			25b. REGISTRAR'S SIGNATURE <i>Jeanne Davidson-Pendell</i>					

10080-0

Transcripted

SEARCHED INDEXED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner should be notified.

FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1 2 2 9 9

00-04973

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a DATE OF DEATH	MONTH	DAY	YEAR	2b HOUR	
Leon Irving McConkey, Sr.						April 21, 1986				12:50 P	
3. SEX		4. RACE		5. DATE OF BIRTH		6 AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR			
Male		Caucasian		Month Day Year May 18, 1920		65		IF UNDER 24 HRS MONTHS DAYS HOURS MIN.			
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH		YRS			
Washington D.C.		U.S.A.				Prince George's					
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b KIND OF BUSINESS OR INDUSTRY		MD.			
Clinton		Southern Maryland Hospital		Architect		U.S. Gov't.					
13. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)						13e STREET ADDRESS / ZIP CODE					
13a STATE Maryland	13b COUNTY P.G.	13c CITY OR TOWN Brandywine	13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS / ZIP CODE 13900 S. Springfield Rd. 20613						
14. FATHER'S NAME FIRST Irving			MIDDLE	LAST McConkey	15. MOTHER'S MAIDEN NAME FIRST Ethel		MIDDLE	LAST Jett			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WW-2		17. INFORMANT		ADDRESS					
		579-16-8103		Leon I. McConkey, Jr. Same as Line #13							
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
<i>Cardiopulmonary arrest</i>											
DUE TO, OR AS A CONSEQUENCE OF (b) <i>Septic Shock</i>											
DUE TO, OR AS A CONSEQUENCE OF (c) <i>Urinary Tract Infection</i>											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY?		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
						YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTICE MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)							
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT HOME <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET		CITY OR TOWN		COUNTY	STATE		
22a I certify that (I) (we) attended the deceased from 1985 , to 1986 , saw the deceased alive on 2/2/86 at 19-86 and that (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						22b DATE SIGNED 4-22-86					
22d PHYSICIAN'S NAME (TYPE OR PRINT) Rene E. Grace, M.D.						22e ADDRESS 9131 Piscataway Road, Clinton, Md. 20735					
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 4-24-86		23c NAME OF CEMETERY OR CREMATORIAL Gate of Heaven Cemetery		23d. LOCATION CITY OR TOWN Silver Spring, Mont., Md.		COUNTY	STATE		
24. FUNERAL DIRECTOR FRANCIS GASCH'S SONS FUNERAL HOME, P.A. ADDRESS 4739 Baltimore Ave, Hyattsville, Md.						25a DATE REC'D. BY REGISTRAR APR 28 1986		25b REGISTRAR'S SIGNATURE Sylvia Swanson-Pendleton			

51040-00

2001, 12 Dec. 1968 - 1969

1001

Second term

Last year conference meeting

20-20-1

2000, 12 Dec. 1968 - 1969

1000, 12 Dec. 1968 - 1969

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked & Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH													
REG. NO. 8 6 1 2 3 0 0													
1. DECEASED NAME (TYPE OR PRINT)			FIRST EDNA	MIDDLE MAE	LAST McCORD	2a. DATE OF DEATH APRIL 10, 1986			MONTH YEAR	DAY	YEAR		
3. SEX Female			4 RACE White		5 DATE OF BIRTH Month June 3, 1917 Day	6. AGE (IN YEARS LAST BIRTHDAY) 68			IF UNDER 1 YEAR MONTHS		IF UNDER 24 HRS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania			7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's			MD.				
10 CITY OR TOWN OF DEATH Lanham			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Doctors' Hospital of Pr. Geo. Co.			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife			12b. KIND OF BUSINESS OR INDUSTRY Own Home				
13a. STATE Md.		13b. COUNTY P.G.		13c. CITY OR TOWN Lanham		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 7008 Kapner Ct. 20706					
14. FATHER'S NAME FIRST Edward			MIDDLE Lynch	LAST	15. MOTHER'S MAIDEN NAME FIRST Sadie			MIDDLE	LAST Heinbach				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No			16b. SOCIAL SECURITY NO. 180-09-2658			17. INFORMANT Barry J. McCord			ADDRESS 4320 Rockport Lane Bowie, Md. 20715				
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>cardiac arrest</i>												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>15 min</i>	
DUE TO, OR AS A CONSEQUENCE OF (b) <i>acute myocardial infarct</i>												<i>66</i>	
DUE TO, OR AS A CONSEQUENCE OF (c) <i>acute cerebral heart disease</i>												<i>year</i>	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>chronic congestive failure -</i>													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN	COUNTY	STATE		
22a. I certify that (I) (this hospital) attended the deceased from <i>Apr 7, 1986</i> to <i>Apr 10, 1986</i> , that (I) (we) last saw the deceased alive on <i>Apr 7, 1986</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE <i>J. Bergemann</i>			22c. DEGREE <i>R.D.</i>			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22d. DATE SIGNED <i>4-10-1986</i>				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Till Bergemann, M.D.			22e. ADDRESS 115 Centerway, Greenbelt, Md. 20770										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 4/14/86			23c. NAME OF CEMETERY OR CREMATORIAL Gate of Heaven			23d. LOCATION CITY OR TOWN Silver Spring Mont. Md.				
24 FUNERAL DIRECTOR NAME Reidson/Hale Lanham			24b. FUNERAL HOME 9013 Annapolis Rd. Lanham, Md. 20706			25a. DATE REC'D. BY REGISTRAR APR 15 1986			25b. REGISTRAR'S SIGNATURE <i>11-5-1986</i>				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
REG. NO. 8012301											
1 - STATE REGISTRAR			1. DECEASED NAME FIRST LUTHER MIDDLE LEROY LAST MC COY			2a. DATE OF DEATH April 12, 1986			2b. HOUR 7:50a M		
3. SEX Male			4. RACE White			5. DATE OF BIRTH MONTH 8 DAY 21 YEAR 22			6. AGE (IN YEARS LAST BIRTHDAY) 63 YRS.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland			7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's County MD.		
10. CITY OR TOWN OF DEATH Lanham			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) AMI/Doctors' Hosp. of Pr. Geo. Co.			12a. USUAL OCCUPATION Pipe Coverer			12b. KIND OF BUSINESS OR INDUSTRY RET Construction		
13a. STATE Maryland			13b. COUNTY Pr Geo			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE 8104 D'Arcy ROAD 20747		
14. FATHER'S NAME FIRST Lonzie MIDDLE McCoy LAST			15. MOTHER'S MAIDEN NAME FIRST Elsi MIDDLE May LAST Saylor								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes			16b. SOCIAL SECURITY NO. WWII			17. INFORMANT Ronald Crampton			ADDRESS Same as #13		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Extensive pleural & pulmonary fibrosis APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
DUE TO, OR AS A CONSEQUENCE OF (b) _____											
DUE TO, OR AS A CONSEQUENCE OF (c) _____											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) carcinoma left lung, cirrhosis											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 3/7, 1986, to 4/12, 1986, that (I) (we) last saw the deceased alive on 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Jerry B. Harmon, MD			DEGREE			22c. DATE SIGNED 4-12-86					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) JERRY B. HARMON			ATTENDING PHYSICIAN <input type="checkbox"/> DIRECTOR <input type="checkbox"/> MEDICAL STAFF PHYSICIAN <input type="checkbox"/>								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 16 Apr 1986			23c. NAME OF CEMETERY OR CREMATORY Resurrection Cemetery			23d. LOCATION CITY OR TOWN Clinton COUNTY PG STATE Md		
24 FUNERAL DIRECTOR NAME Robert E Wilhelm Funeral Home			ADDRESS Suitland, Md.			25a. DATE REC'D. BY REGISTRAR APR 22 1986			25b. REGISTRAR'S SIGNATURE John Davidson - Harmon		

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PEN IN ITEM 1 WITH FORM PM. RETAIN PAGE 1 FOR YOUR FILES.
 TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER WITH FORM PM. RETAIN PAGE 3 AS A BURIAL TRUSTEE'S COPY.
 AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PEARSON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR RELEASING.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO. 12302
1- STATE REGISTRAR												
1. DECEASED NAME (TYPE OR PRINT)		FIRST KELSCEN <i>Kelseen</i>	MIDDLE LEMONT <i>Lemont</i>	LAST McGILL <i>McGill</i>	2a DATE KNOWN OF ESTI- DEATH MATED		MONTH APRIL		DAY 6		YEAR 1986	
3. SEX Male		RACE Blk <i>Blk</i>	5. DATE OF BIRTH Mo. Day Year Dec 16 '56 <i>Dec 16 56</i>	6. AGE (IN YEARS) LAST BIRTH YRS. 29 <i>29</i>	7. IF UNDER 1 YR. MONTHS 0	8. IF UNDER 24 HRS. DAYS 0	9. HOURS 0	10. MIN. 0	2b HOUR 4 PM		2b AM	
11. BIRTHPLACE North Carolina		16. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGES <i>Prince George</i>		10. DATE PRONOUNCED DEAD APRIL 6 1986 <i>April 6 1986</i>		10. DATE MONTH APRIL DAY 6 YEAR 1986		
12. CITY OR TOWN OF DEATH LANDOVER <i>Landover</i>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 811 8117 Landover Rd				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Carpenter		12b KIND OF BUSINESS OR INDUSTRY Private				
13. STATE VA		13b COUNTY Alexandria		13c CITY OR TOWN Alexandria		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS 1806 Lechmere Ave #103 <i>1806 Lechmere Ave #103</i>		13f APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
14. FATHER'S NAME FOSTER		MIDDLE	LAST	15. MOTHER'S MAIDEN NAME BEATRICE		16. SOCIAL SECURITY NO. NO 579 76 8984		17. INFORMANT Brother EDWARD McGill 4501 RENA RD		18. GALES		
18a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO		18b. SOCIAL SECURITY NO.		18c. ADDRESS Forestville, Maryland		18d. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Gunshot Wound of Head</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)												
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a <i>None</i>												
19a. DATE OF OPERATION <i>None</i>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20 AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR AM MONTH DAY YEAR PM. 4 6 86 <i>PM. 4 6 86</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) Shot & Cut								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) <i>Home</i>		21f. LOCATION STREET <i>Landover Rd</i>		CITY OR TOWN <i>Landover, Prince George</i>		COUNTY <i>MD</i>				
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>												
ACTUAL SIGNATURE <i>John S. Rogers, M.D.</i>		TITLE (SPECIFY) <i>John S. Rogers, M.D.</i>				MEDICAL EXAMINER		DATE SIGNED <i>April 6 1986</i>				
EXAMINER'S NAME (TYPE OR PRINT)		John S. Rogers				ADDRESS 1919 Seminary Road Silver Spring, MD						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE BURIAL Apr 11, 1986		23c. NAME OF CEMETERY OR CREMATORIAL Fort Lincoln		23d. LOCATION CITY OR TOWN Bladensburg, PG CO. MD						
24. FUNERAL DIRECTOR NAME ALEXANDER S. POPE		ADDRESS 2617 PA AVE SE WASH., D.C.		25a. DATE REC'D. BY REGISTRAR APR 11 1986		25b. REGISTRAR'S SIGNATURE <i>Silvia K. Krieger, R.N.</i>						
DHMH-17 (VR A15 ME (5))												

20% COTTON 70% POLYESTER



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the Hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use in the burial or transit parent. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked as Item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 8012303			
1. DECEASED NAME (TYPE OR PRINT)			MIDDLE			LAST			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
EDNA GREENAWALT McKEE									APRIL 1, 1986			3:10AM	
1c. SEX Female			4. RACE Caucasian			5. DATE OF BIRTH MONTH DAY YEAR June 7, 1893			6. AGE (IN YEARS LAST BIRTHDAY) 92 YRS.			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland			7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Prince Georges MD.				
10. CITY OR TOWN OF DEATH Clinton			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Southern Md. Hosp. Center			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife			12b. KIND OF BUSINESS OR INDUSTRY Home				
13a. STATE Maryland			13b. COUNTY Pr. Geo.			13c. CITY OR TOWN Upper Marlboro			13d. INSIDE CITY LIMITS? NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE 13209 Molly Berry Rd. 20772	
14. FATHER'S NAME Thomas S. Greenawalt			15. MOTHER'S MAIDEN NAME Christina S. Smith										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO. - - - 217-36-6490			17. INFORMANT Claude G. McKee			ADDRESS 13205 Molly Berry Rd. Upper Marlboro, Md.			APPROXIMATE INTERVAL BETWEEN DEATH AND DEATH	
18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive heart failure													
DUE TO, OR AS A CONSEQUENCE OF (b)													
DUE TO, OR AS A CONSEQUENCE OF (c)													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b PART 1 OR PART 2)							
21d. INJURY OCCURRED <input type="checkbox"/> WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from 5 24, 19 73, to 4-1, 19 86, that (I) (we) last saw the deceased alive on 3 31, 19 86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE W.H. Furst			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 4-1-86				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) William K. Furst, M.D.			22e. ADDRESS 11701 Livingston Rd., Ft. Washington, Md.										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 4-3-86			23c. NAME OF CEMETERY OR CREMATORY Brookfield U.M.Cem			23d. LOCATION CITY OF OWN Naylor, Pr. Geo., Md. STATE				
24. FUNERAL DIRECTOR NAME Huntt Funeral Home			ADDRESS P. O. Box 156 Waldorf, Md 20601			25a. DATE REC'D. BY REGISTRAR APR 03 1986			25b. REGISTRAR'S SIGNATURE John Davidson Pendle				

6 - 1

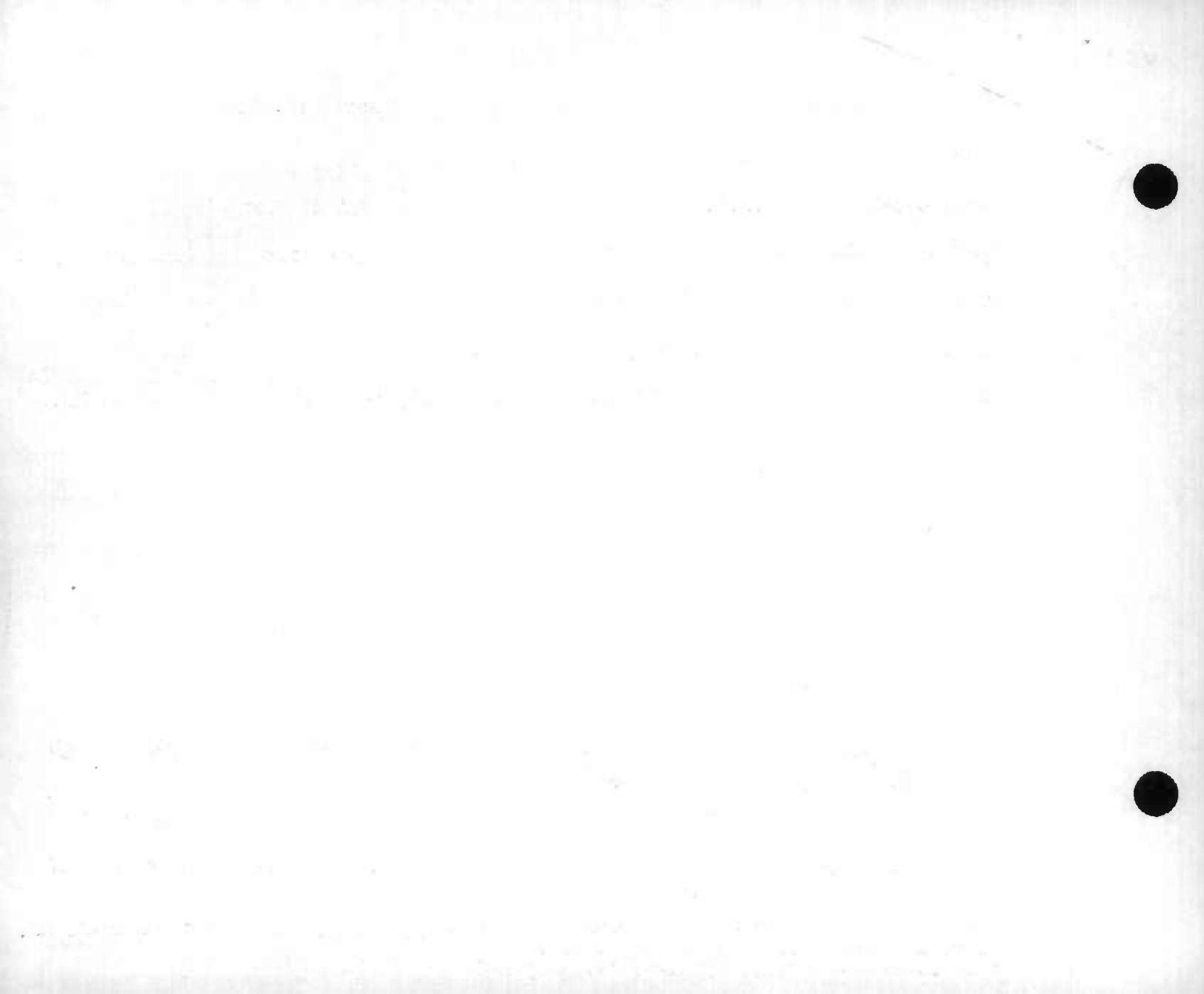
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death.

IMPORTANT: If item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 8 6 1 2 3 0 4								
1- FOR STATE REGISTRAR			2a DATE OF DEATH MONTH DAY YEAR April 15, 1986							2b HOUR 6:30 pm								
1. DECEASED NAME (TYPE OR PRINT)			FIRST		MIDDLE		LAST		6. AGE [IN YEARS LAST BIRTHDAY] 71		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.					
Robert Lee							McKinney		YRS.									
3. SEX Male			4. RACE Caucasian		5. DATE OF BIRTH MONTH 09 DAY 24 YEAR 14		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's MD.		10. BIRTHPLACE (STATE OR FOREIGN COUNTRY) North Carolina		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Landover Hills 3802 58th Avenue		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Upholster		12b. KIND OF BUSINESS OR INDUSTRY Bus Company	
13a. STATE Maryland			13b. COUNTY Prince George		13c. CITY OR TOWN Landover Hills		13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 3802 58th Avenue 20784		14. FATHER'S NAME FIRST Walter MIDDLE McKinney LAST		15. MOTHER'S MAIDEN NAME Cenia		16. ADDRESS Burleson			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. 212-14-1318		17. INFORMANT Mrs. Dorothy McKinney		18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c.) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchogenic Carcinoma		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
							DUE TO, OR AS A CONSEQUENCE OF (b)											
							DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a																		
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)												
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE												
22a. I certify that (I) (this hospital) attended the deceased from 1975, to 1975, that (I) (we) last saw the deceased alive on 4-15, 1986, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.																		
22b. SIGNATURE Louis Steinberg			DEGREE MD			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 4-16-86									
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Louis Steinberg			22e. ADDRESS 6492 Landover Rd Landover Rd															
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 4-19-86		23c. NAME OF CEMETERY OR CREMATORIAL Cedar Hill Cemetery		23d. LOCATION CITY OR TOWN Suitland		23e. COUNTY Prince George's Md.		23f. STATE							
24. FUNERAL DIRECTOR (NAME) FRANCIS GASCH'S SONS FUNERAL HOME, P.A. 4739 Baltimore Avenue, Hyattsville, Maryland						25a. DATE REC'D. BY REGISTRAR APR 21 1986		25b. REGISTRAR'S SIGNATURE Silvana Anderson										



00-05375

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3, RETAIN PAGE 5 FOR YOUR FILES. PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS, AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MD. 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 2305

1- STATE REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)		FIRST <i>Willie</i>	MIDDLE <i>McNeil</i>	LAST	2a. DATE KNOWN OF ESTI- DEATH MATED	MONTH DAY YEAR <i>4-21 1986</i>	2b. HOUR M	
3. SEX <i>Male</i>	4. RACE <i>Black</i>	5. DATE OF BIRTH MONTH DAY YEAR <i>May 23, 1932</i>	6. AGE (IN YEARS LAST BIRTHDAY) 53 YRS	7. IF UNDER 1 YR. MONTHS DAYS	8. IF UNDER 24 HRS. HOURS MIN.	9c. DATE PRONOUNCED DEAD	7d. HOUR M <i>8:30 AM</i>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) NORTH CAROLINA		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED		9. BALTIMORE CITY OR COUNTY OF DEATH NEW CARROLLTON		
10. CITY OR TOWN OF DEATH NEW CARROLLTON		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Doctors Hosp.			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) PARALEGAL			
13a. STATE MARYLAND		13b. COUNTY P.G.		13c. CITY OR TOWN NEW CARROLLTON		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST DAN		MIDDLE 	LAST MCNEIL	15. MOTHER'S MAIDEN NAME FIRST RUTH		MIDDLE 	LAST MCNEIL MANN	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) YES			16b. SOCIAL SECURITY NO. 578-36-7262			17. INFORMANT ADDRESS LATTICE MCNEIL 7420 LONGBRANCH DR		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: <i>8120</i> IMMEDIATE CAUSE (a): <i>Renal failure and cardiorespiratory</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause lost. (b): (c): APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH								
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). <i>Rib fractures</i>								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <i>4/15 1986</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) <i>Driver of triple vehicle impact</i>				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) <i>Street</i>		21f. LOCATION STREET <i>Riverside Rd & Lamont Dr, New Carrollton, P.G. Geo</i>		CITY OR TOWN <i>New Carrollton, P.G. Geo</i>	STATE <i>MD</i>	
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion								
ACTUAL SIGNATURE <i>Augusto P. Rodriguez</i>		TITLE (SPECIFY) M.D. <i>Deputy</i>				DATE SIGNED <i>4-22-86</i>		
EXAMINER'S NAME (TYPE OR PRINT) <i>Augusto P. Rodriguez, M.D.</i>		ADDRESS 5009 Rayburn Ct, Temple Hills, MD						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 4/26/86	23c. NAME OF CEMETERY OR CREMATORIAL GEO. WASHINGTON CEM.		23d. LOCATION CITY OR TOWN 	COUNTY P.G.	STATE MD	
24. FUNERAL DIRECTOR NAME J.B. JENKINS F.H.		ADDRESS 7474 LANDOVER RD LANDOVER MD	25a. DATE REC'D. BY REGISTRAR MAY 02 1986					

1867-00

James G. Wadsworth
665 SO YAN

00-04068

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B, AND 3 TO THE JURIDICAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM. 3 RETAIN PAGE 5 TO YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS, AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 12306

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a DATE KNOWN OF ESTI- DEATH MATED	MONTH	DAY	YEAR	2b. HOUR
<i>Luther</i>			<i>Morrison</i>			<input type="checkbox"/>	4-15	19	86	M
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS MONTH DAY YEAR LAST BIRTHDAY)	7. IF UNDER 1 YR.	8. IF UNDER 24 HRS.	9. DATE PRONOUNCED DEAD	MONTH	DAY	YEAR	2d. HOUR
Male	Black	02 11 1938	48 yrs.	MONTHS	DAYS	4-15	1986	845	A.M.	
10. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	11. CITIZEN OF WHAT COUNTRY?	12. MARRIED WIDOWED	13. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	14. CITY OR TOWN OF DEATH	15. MOTHER'S MAIDEN NAME	16. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)	17. INFORMANT	18. DATE OF OPERATION	19. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY?
Edgewater, SG	U.S.	<input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED	Prince Georges General Hospital Plumber	Lanham	Rosanna Scott	Prince George's General Hospital	Delorise Merriweather	55C9 Central Ave, S.E.	55C9 Central Ave, S.E.	ADDRESS
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS	14. FATHER'S NAME	15. MOTHER'S MAIDEN NAME	16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)	16b. SOCIAL SECURITY NO.	17. INFORMANT	APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
DC		Washington	NO	5569 Central Ave, S.E.	Luther	Merriweather	(YES, NO, OR UNKNOWN)	248-64-0907	Delorise Merriweather	55C9 Central Ave, S.E.
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Arteriosclerotic cardiovascular disease</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause lost.										
(b) DUE TO, OR AS A CONSEQUENCE OF										
(c) DUE TO, OR AS A CONSEQUENCE OF										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).										
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY?								
19c. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)	21f. LOCATION STREET	CITY OR TOWN	COUNTY	STATE					
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .										
ACTUAL SIGNATURE <i>Augusto P Rodriguez</i> TITLE (SPECIFY) EXAMINER'S NAME (TYPE OR PRINT) Augusto P Rodriguez, M.D. M.D. Deputy MEDICAL EXAMINER										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORIAL	23d. LOCATION CITY OR TOWN	COUNTY	STATE					
Burial	4/20/86	Pleasant Grove Bapt. Chrd	Edgewater		SC					
24. FUNERAL DIRECTOR NAME	ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE							
Robert G. Mason	161 Good Hope Rd, SE	APR 18 1986	<i>John D. Anderson</i>							

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DHMH - 17
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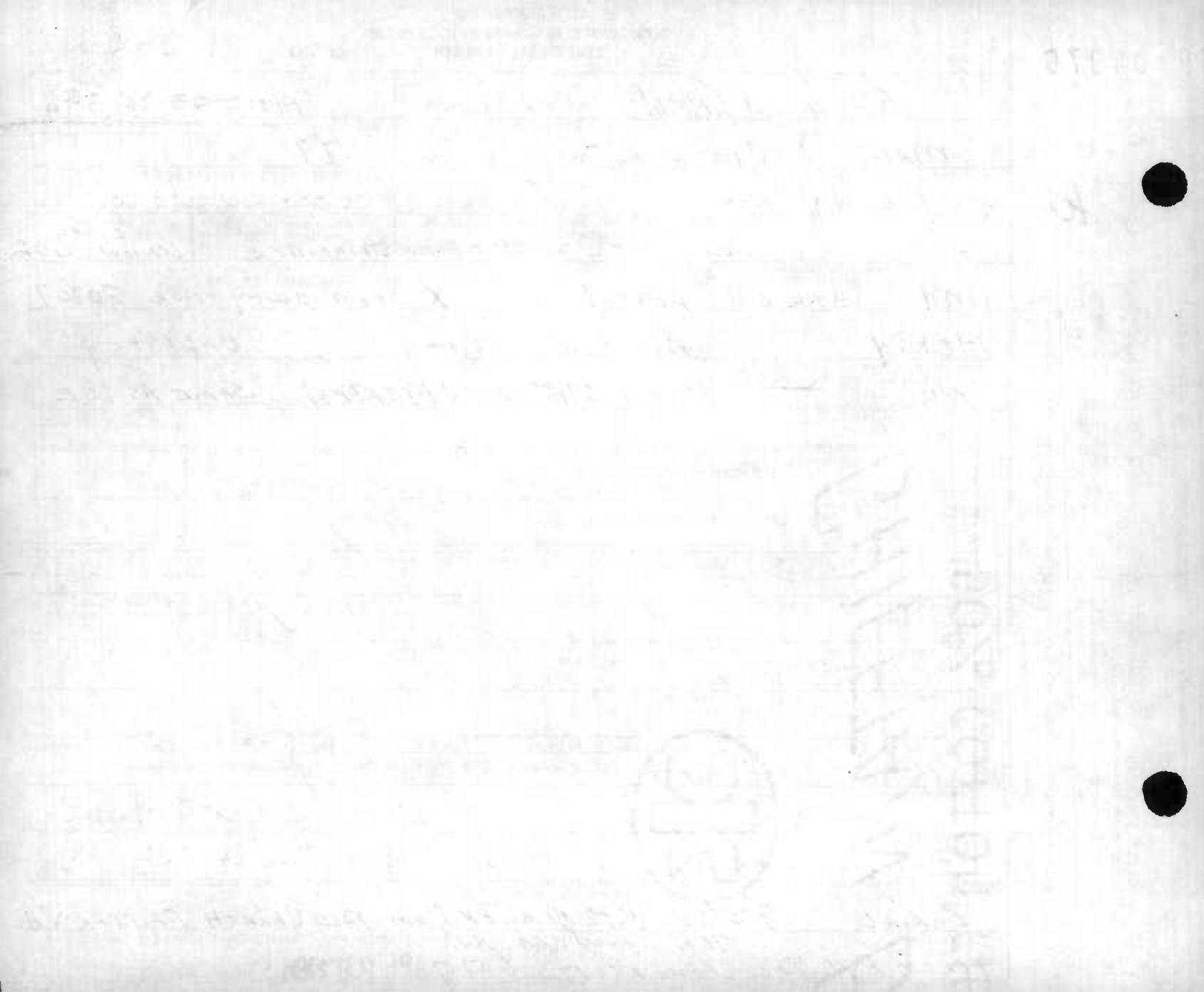
00-04976

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and certified in by the funeral director, page 3 should be detached for use as the burial permit. Then please remove carbon paper. Page 1 and 2 should be filed in the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury or other traumatic event, the medical examiner may be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH													
8 6 2 3 0 7 REG. NO.													
1. DECEASED NAME (TYPE OR PRINT)			FIRST			MIDDLE			LAST				
<i>Raymond (NMN) merten</i>													
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			26. HOUR			
MALE		CAUCASIAN		JULY 16 06			79 YRS.			3:30 AM			
7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH						
New York - N.Y.		USA		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			Prince George's Co. MD.						
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)											
Laurel		Greater Laurel Nursing Home STEAMFITTER											
12. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) THE STATE		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE						
Md		Howard Laurel		NO			16 Midway - Ave 20707						
14. FATHER'S NAME FIRST		MIDDLE		15. MOTHER'S MAIDEN NAME FIRST			MIDDLE						
Henry				Mary			Balister						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT			ADDRESS						
No		577-09-6715		HELEN MERTEN			SAME AS 13e						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)													
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardio-pulmonary Arrest</i>													
DUE TO, OR AS A CONSEQUENCE OF (b) <i>Metastatic leiomyosarcoma</i>													
DUE TO, OR AS A CONSEQUENCE OF (c)													
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE			
22a. I certify that (I) (this hospital) attended the deceased from November 19 85 to April 23 19 86, that (I) (we) last saw the deceased alive on 4/15 19 86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE <i>B.K. Lance, M.D.</i>		DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/>		MEDICAL DIRECTOR <input type="checkbox"/>		STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 4/23/86			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Barry K. Lance, M.D.</i>		22e. ADDRESS 14201 Laurel Park Dr, Suite 223 Laurel, MD											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>BURIAL</i>		23b. DATE <i>4/25/86</i>		23c. NAME OF CEMETERY OR CREMATORIUM <i>Natl. Memo. Pk. Cem.</i>			23d. LOCATION CITY OR TOWN <i>Falls Church</i>		COUNTY <i>FAIRFAX</i>		STATE <i>VA.</i>		
24. FUNERAL DIRECTOR NAME <i>FLECK F.H. INC.</i>		ADDRESS <i>7601 Sandy Spring Rd.</i>		25a. DATE RECD. BY REGISTRAR <i>APR 28 1986</i>			25b. REGISTRAR'S SIGNATURE <i>J. L. Lewisson - Hendon</i>						



00-02567

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 18 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												
8 REG. NO. 1 2 3 0 8												
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH			MONTH	DAY	YEAR	
LAURA			E.	Milbourn		4-2-86					1986	
3. SEX			4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)			2b. HOUR		
F			Caucasian		MONTH 10 - DAY 31 - YEAR 04		81			9 P.M.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
Leland, Maryland			U.S.A.				Prince George's					
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY					
Forestville			Regency Nursing Home		Procurement		U.S. Government					
13. STATE			13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE					
Maryland			Prince George's	Forestville			2100 Brooks Dr. 20747					
14. FATHER'S NAME			FIRST Horace	MIDDLE Bernard	LAST Wells	15. MOTHER'S MAIDEN NAME		16. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
						FIRST Maggie E.		30 minutes				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.		17. INFORMANT (nephew) Horace B. Wells		ADDRESS					
NO							12513 Kilbourne La. Bowie, MD 20715					
18. CAUSE OF DEATH (Enter only one cause per line for 1a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIOPULMONARY ARREST												
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____												
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1b. CANCER OF CERVIX												
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b PART I OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE	
22a. I certify that (I) (this hospital) attended the deceased from saw the deceased alive on 3/22 1986, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			19 85 , to 3/22 1986									
22b. SIGNATURE Edward T. Cullen Jr.			22c. DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22d. DATE SIGNED 4/3/86					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Edward T. Cullen			22e. ADDRESS 5103 Marlboro Pike Capitol Heights, MD 20743									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE April 15, 1986		23c. NAME OF CEMETERY OR CREMATORIAL Cedar Hill Cemetery		23d. LOCATION CITY OR TOWN Suitland, Prince George's, MD			COUNTY		STATE
24. FUNERAL DIRECTOR NAME Lee Funeral Home, Inc. 6633 Old Alexander Ferry Rd., Clinton, MD 20735							25a. DATE REC'D. BY REGISTRAR APR 04 1986			25b. REGISTRAR'S SIGNATURE		

00-03261

1850

00-05501

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be detached for use as the burial/transit permit. Then please remove and mail with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH						REG. NO. 8512309					
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH MONTH DAY YEAR	MONTH	DAY	YEAR	2b. HOUR IF UNDER 24 HRS. HOURS MIN.	
FRANCIS G. MILLER						27 Apr 86				1648 M	
3. SEX Male		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR Sept. 21, 1917		6. AGE (IN YEARS LAST BIRTHDAY) 68 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Missouri		7b. CITIZEN OF WHAT COUNTRY? USA		7c. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince Georges MD.					
10. CITY OR TOWN OF DEATH Andrews AFB		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Malcolm Grow Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Adm.		12b. KIND OF BUSINESS OR INDUSTRY US Navy					
13a. STATE New Jersey		13b. COUNTY Gloucester		13c. CITY OR TOWN Deptford		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 1100 Monmouth Rd. 99999			
14. FATHER'S NAME FIRST Harry		MIDDLE		LAST Miller		15. MOTHER'S MAIDEN NAME UNKNOWN					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. WW II		16c. INFORMANT Daughter: Harriett Hall		17. ADDRESS Wenonah, NJ					
18. CAUSE OF DEATH (Enter only one cause per line for Part I.) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiac arrest</i>						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
DUE TO, OR AS A CONSEQUENCE OF (b) <i>Chronic obstructive pulmonary disease</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.											
DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE	
22a. I certify that (I) (we) attended the deceased from 18 Apr 86, to 19 Apr 86, that (I) (we) last saw the deceased alive on 27 Apr 1986 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.											
22b. SIGNATURE <input checked="" type="checkbox"/>		22c. DEGREE <i>Shirley Lockie RN</i>				ATTENDING PHYSICIAN <input type="checkbox"/>		MEDICAL DIRECTOR <input type="checkbox"/>		STAFF <input checked="" type="checkbox"/>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Shirley Lockie</i>		22e. ADDRESS MALCOLM GROW MEDICAL CENTER ANDREWS AFB MD 20331-5300				22f. DATE SIGNED 4-28-86					
23a. BURIAL, CREMATION, REMOVAL cremation		23b. DATE May 1, 1986		23c. NAME OF CEMETERY OR CREMATORIAL Ferris & Co. Crematory		23d. LOCATION Westchester, Pa.					
24. FUNERAL DIRECTOR NAME Ives-Pearson Funeral Homes Arlington, Va. 22201		25a. DATE REC'D. BY REGISTRAR MAY 02 1986		25b. REGISTRAR'S SIGNATURE <i>John T. Johnson, Jr.</i>							

14330-00

ALL INFORMATION CONTAINED
HEREIN IS UNCLASSIFIED
DATE 04-16-2010 BY SP2 JAS

SEARCHED INDEXED SERIALIZED FILED
JUN 16 2000

Released by Dr. Capone

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or if item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO. 8612310				
1- FOR STATE REGISTRAR			1. DECEASED NAME (TYPE OR PRINT)			MIDDLE			LAST			2a DATE OF DEATH	MONTH	DAY	YEAR	2b HOUR
			PAULINE N MILLER.									4-23-86				11 P.M.
3. SEX			4. RACE			5 DATE OF BIRTH MONTH DAY YEAR			6 AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS		
Female			Caucasian			January 9, 1910			76			YRS.	MONTHS	DAYS	HOURS	MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH			12b. KIND OF BUSINESS OR INDUSTRY				
Penn.			U.S.A.						PRINCE George's Co MD			US Govt.				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)							
Clinton			St. MARYLAND Hospital			Secretary Dept of Cen.										
13a. STATE Maryland			13b. COUNTY P. G.			13c. CITY OR TOWN Morningside			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE 4414 Morgan Road		20746		
14. FATHER'S NAME FIRST Andrew			MIDDLE Noel			15. MOTHER'S MAIDEN NAME FIRST Anna			LAST Grove			ADDRESS 10419 Julep Ave, Sil. Spg. Md 20902				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) N/A			17. INFORMANT Julie Ann Sonn			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory Failure</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Severe Chronic Obstructive Pulmonary Disease</u> DUE TO, OR AS A CONSEQUENCE OF (c)			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost																
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>Pneumonia, Dehydration, sinus tachycardia</u>																
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED. (ENTER NATURE OF INJURY IN ITEM 1b. PART 1 OR PART 2)										
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE										
22a. I certify that (I) (this hospital) attended the deceased from <u>April 23</u> , 1986, to <u>April 23</u> , 1986, that (I) (we) lost saw the deceased alive on <u>April 23</u> , 1986, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																
22b. SIGNATURE <u>Helen Capone</u>			22c. DEGREE MD			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22d. DATE SIGNED <u>April 24, 1986</u>							
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Helen D. CAPONE</u>			22e. ADDRESS <u>7501 Surratts Rd Clinton Md 20735</u>													
23a. BURIAL, CREMATION, REMOVAL (SPECIES)			23b. DATE 04/28/86			23c. NAME OF CEMETERY OR CREMATORIAL Resurrection Cemetery			23d. LOCATION CITY OR TOWN Clinton			COUNTY P.G.		STATE Maryland		
24. FUNERAL DIRECTOR NAME Lee Funeral Home, Inc.			24. FUNERAL DIRECTOR NAME Lee Funeral Home, Inc.			24. FUNERAL DIRECTOR NAME Lee Funeral Home, Inc.			25a. DATE REC'D. BY REGISTRAR 25. DATE REC'D. BY REGISTRAR APR 25 1986			25b. REGISTRAR'S SIGNATURE				
6633 Old Alexander Ferry Rd, Clinton, Maryland																

CHARTER VESSEL
NAME UNKNOWN - NO. 1000
LNG ID 8401080

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 3 may be resubmitted by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/cremation permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

(INFORMANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified.)

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
REG. NO. 80-12311											
1 - FOR STATE REGISTRAR			I. DECEASED NAME FIRST Stephen J. MIDDLE LAST Miller			2a. DATE OF DEATH MONTH June 18 YEAR 1905			2b. HOUR 4-30-86 12:26 P		
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH June DAY 18 YEAR 1905			6. AGE (IN YEARS LAST BIRTHDAY) 80 YRS.			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia			7b. CITIZEN OF WHAT COUNTRY? USA			MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's County MD.		
10. CITY OR TOWN OF DEATH Morningside			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 4414 Morgan Rd.			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Cost Analyst			12b. KIND OF BUSINESS OR INDUSTRY U.S. Govt.		
13a. STATE Maryland			13b. COUNTY P.G.			13c. CITY, OR TOWN Morningside			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST Michael			MIDDLE Miller			15. MOTHER'S MAIDEN NAME Julia			13e. STREET ADDRESS / ZIP CODE 4414 Morgan Road 20746		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) N/A			17. INFORMANT Julie A. Sonn			ADDRESS 10419 Julep Ave. Silver Spring, Md 20902		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory failure DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Chronic obstructive lung disease DUE TO, OR AS A CONSEQUENCE OF (c)											
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from March 19 86 to April 19 86, that (I) (we) last saw the deceased alive on above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Howard Goldberg MD			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 5/1/86		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Howard Goldberg			22e. ADDRESS 12012 Veirs Mill Rd. Wheaton, Md. 20906								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 05/02/86			23c. NAME OF CEMETERY OR CREMATORIAL Resurrection Cemetery			23d. LOCATION CITY OR TOWN Clinton		
24. FUNERAL DIRECTOR NAME Lee Funeral Home, Inc.			25a. DATE REC'D. BY REGISTRAR MAY 2 1986			25b. REGISTRAR'S SIGNATURE June Davidson-Hendrie			COUNTY Prince George's MD STATE		
6633 Old Alexander Ferry Rd. Clinton Md 20735											

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death be executed within 24 hours after death. Page 4 may be

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please return to the medical examiner. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or medical examiner must be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH													
8 6 1 2 3 1 2											REG. NO.		
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR	
Carroll					Mitchell	4 - 10 - 86					100	1/2 M	
3. SEX			4. RACE		5. DATE OF BIRTH			MONTH	DAY	YEAR	6. AGE [IN YEARS LAST BIRTHDAY]		
Male			Black		11 - 19 - 20			11	19	20	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED			<input checked="" type="checkbox"/>	NEVER MARRIED	<input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH		
Maryland			U.S.		WIDOWED			<input type="checkbox"/>	DIVORCED	<input checked="" type="checkbox"/>	Prince Georges MD		
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY				
Forestville			Regency			Retired Butcher			Private Industry				
13a. STATE D. C.			13b. COUNTY		13c. CITY OR TOWN Washington			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE 1833 New Hampshire Ave., N. W. #312		
14. FATHER'S NAME FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST										
Cornelius Mitchell			Not Stated										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS				
Yes WW II			577-40-1684			Theresa Mitchell, Daughter, Washington, DC			1833 N. H. Ave., NW 312				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Gastro Intestinal Hemorrhage</i> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH DUE TO, OR AS A CONSEQUENCE OF (b) <i>Ca of Colon Peritonitis</i> 1 day Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) DUE TO, OR AS A CONSEQUENCE OF													
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) <i>Dehydration, Diabetes, CVA, Chemparesis, amputation</i>													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/>				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN				
22a. I certify that (I) (this hospital) attended the deceased from saw the deceased alive on 4/10/86 to 4/10/86, 1986, that (I) (we) last above. (If we did not view the body after death.)									COUNTY				
22b. SIGNATURE			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			STATE				
22c. PHYSICIAN'S NAME (TYPE OR PRINT)			22d. ADDRESS			4/10/86			4/10/86				
KELVIN L MINCHIN			6188 OXON HILL RD OXON HILL										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN				
BURIAL			15 Apr 86			Quantico Nat Cem			COUNTY				
24. FUNERAL DIRECTOR NAME			ADDRESS			Triangle, Virginia			STATE				
W. ERNEST JARVIS CO., INC., Washington, D.C.			1432 You ST., NW			APR 23 1986			John Anderson-Pender				

100-10-00

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00-02820
00-02820STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 6 6 1 2 3 1 3

1 - STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR	
			Annie	Beverly	Mohler	April 4, 1986				9:45P M	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS.	
Female		caucasian		Jan 29 1899		87		YRS.		MONTHS DAYS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8		MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH		10 CITY OR TOWN OF DEATH	
Virginia		USA						Prince Georges County		Laurel	
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)									
Greater Laurel Beltsville Hospital		OFFICE									
13a. STATE		13c. COUNTY		13d. CITY OR TOWN		13e. INSIDE CITY LIMITS?		13f. STREET ADDRESS / ZIP CODE			
Md.		Montgomery		Burtonsville		<input type="checkbox"/> NO <input checked="" type="checkbox"/>		14912 Perrywood Dr. 20866			
14. FATHER'S NAME		FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME		FIRST	MIDDLE	LAST		
		Jack		England			Nancy		Unkown		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS		18. CAUSE OF DEATH (Enter only one cause per line for 18, 19, and 20) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)			
yes		WWII		226-01-6517		Robert Phipps same as 13e		RESPIRATORY FAILURE.			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.				DUE TO, OR AS A CONSEQUENCE OF (b) STROKE (C.V.A.)				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
				DUE TO, OR AS A CONSEQUENCE OF (c) Cerebral vascular disease							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
								<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE	
22a. I certify that (I) (this hospital) attended the deceased from 3-19-1986 to 4-4-1986, that (I) (we) last saw the deceased alive on 4-4-1986, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. MEDICAL CERTIFICATION DEGREE											
22c. DATE SIGNED		4/5/86									
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		ATTENDING PHYSICIAN <input checked="" type="checkbox"/>		MEDICAL DIRECTOR <input type="checkbox"/>		STAFF PHYSICIAN <input type="checkbox"/>		22e. ADDRESS		22f. ADDRESS	
M. H. CHALEB H. JR.								1420 Laurel Park Drive #100		Laurel Md. 20707	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS		23d. LOCATION CITY OR TOWN		CITY OR TOWN		COUNTY	
Cremation		4/6/86		BETH. WASH. Crematory		Laurel		Laurel		Md.	
24. FUNERAL DIRECTOR NAME		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE							
FLECK F.H. INC.		APR 07 1986									
ADDRESS											
LAUREL, MD. 20707											

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 shall be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, in medical report

DHMH - 16 60M 7/84
(VRA 15, 4)

05500-00

SOVEREIGN
BANK OF CANADA

MEDICAL EXAMINER NOTIFIED

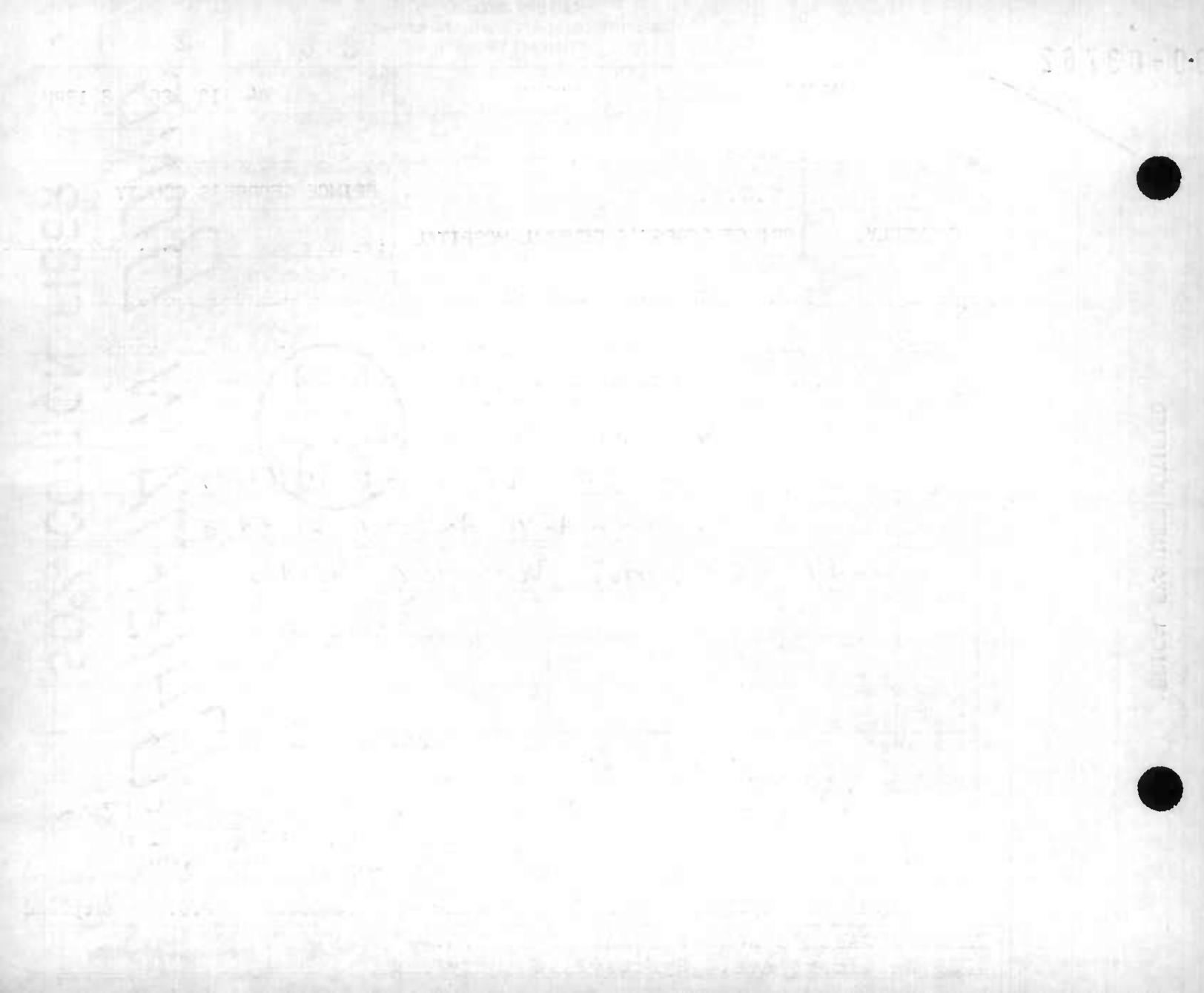
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Reg. 4 may be rebinned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, the funeral director (page 1 and 2) should be filled in by the funeral director (page 3). Item please remove carbon papers. Pages 1 and 2 should be filed in item 72 hours after death. Should be detached for use as the burial permit. Item please remove carbon papers. Pages 1 and 2 should be filed in item 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury or other traumatic event, list medical examiner's name in item 21.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH													
REG. NO. 12314													
1. RELEASED NAME (TYPE OR PRINT)			FIRST HAROLD	MIDDLE EUGENE	LAST MOOMAW		2d. DATE OF DEATH 04	MONTH 12	DAY 86	2d. HOUR 8 18PM _M			
3. SEX Male		4. RACE Caucasian		5. DATE OF BIRTH MONTH May 12, 1927		YEAR	6. AGE (IN YEARS LAST BIRTHDAY) 58 YRS.		IF UNDER 1 YEAR MONTHS 0		IF UNDER 24 HRS HOURS 8 MIN. 15		
7a. BIRTHPLACE STATE OR FOREIGN COUNTRY Virginia		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGE'S COUNTY						
10. CITY OR TOWN OF DEATH CHEVERLY		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION PRINCE GEORGE'S GENERAL HOSPITAL		12a. USUAL OCCUPATION Printer		12b. KIND OF BUSINESS OR INDUSTRY U.S. Government							
13a. STATE Maryland		13b. COUNTY P.G.		13c. CITY OR TOWN Landover Hills		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 6732 Darby Road 20784					
14. FATHER'S NAME Earle		FIRST R. MIDDLE Moonaw		15. MOTHER'S MAIDEN NAME Lillian		16. ADDRESS I. Ering							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO W.W.II		16c. PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		17. INFORMANT Mary L. Moomaw (Wife) Same as #13		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c.)		18b. DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last		18c. DUE TO, OR AS A CONSEQUENCE OF (b) CONGESTIVE HEART FAILURE		18d. (c) CORONARY ARTERY DISEASE							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a CHRONIC OBSTRUCTIVE PULMONARY DISEASE													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE			
22a. I certify that (I) (this hospital) attended the deceased from 19 82 to 19 86, that (I) (we) last saw the deceased alive on 4.5.19 86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE <i>V.P. Singh</i>		22c. DEGREE M.D.		22d. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22e. DATE SIGNED 4.13.86							
22d. PHYSICIAN'S NAME (TYPE OR PRINT) V. P. SINGH		22e. ADDRESS 5632 ANNAPOLIS RD. BLADENSBURG MD 20710											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 04/16/86		23c. NAME OF CEMETERY OR CREMATORIAL Fort Lincoln Cemetery		23d. LOCATION CITY OR TOWN Brentwood		COUNTY P.G.		STATE Maryland			
24. FUNERAL DIRECTOR NAME FRANCIS GASCH'S SONS FUNERAL HOME, P.A. 4739 Baltimore Ave., Hyattsville, Maryland				25a. DATE REG'D. BY REGISTRAR 4/16/86		25b. REGISTRAR'S SIGNATURE <i>John Anderson</i>							
(VRA 15, 4)													



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in full, mail it, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 will be filled in within 72 hours after death, with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner will be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH						REG. NO. 8612315
1. FOR STATE REGISTRAR						
1. DECEASED NAME (TYPE OR PRINT)		FIRST Raymond	MIDDLE (N.M.I.)	LAST Morauer	2a DATE OF DEATH April 10, 1986	MONTH DAY YEAR
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH April DAY 6 YEAR 1899	6. AGE (IN YEARS LAST BIRTHDAY) 87	IF UNDER 1 YEAR MONTHS YRS.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Austria		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's County	
10. CITY OR TOWN OF DEATH Mitchellville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 4208 Glenn Dale Road			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Contractor	12b. KIND OF BUSINESS OR INDUSTRY Excavation
13a. STATE Maryland		13b. COUNTY P.G.	13c. CITY OR TOWN Mitchellville	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 4208 Glenn Dale Road 20716	
14. FATHER'S NAME FIRST Carl		MIDDLE 	LAST Morauer	15. MOTHER'S MAIDEN NAME FIRST Maria	MIDDLE 	LAST Schiedel
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 578-12-7471		17. INFORMANT Roy Morauer (Son)	Rt. # ADDRESS Box 398 Billingsley Rd., Mitchellville, Md.	
18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIO RESPIRATORY ARREST DUE TO, OR AS A CONSEQUENCE OF (b) POSSIBLE ACUTE MYOCARDIAL INFARCTION Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) 						
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) GEREBSKOVASCULAR DISEASE						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART I OR PART II)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET	CITY OR TOWN	COUNTY	STATE
22a. I certify that (I) (this hospital) attended the deceased from 5/1/86 , to 3/29/86 , that (I) (we) last saw the deceased alive on 3/29/86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did/did not view the body after death.						
22b. SIGNATURE <i>S. Nachnani</i>		DEGREE		22c. DATE SIGNED Apr. 10, 1986		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Gurbux H. Nachnani, M.D.		22e. ADDRESS 8926 Woodyard Road # - 601 Clinton, Maryland 20735				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 04/14/86	23c. NAME OF CEMETERY OR CREMATORIAL Fort Lincoln Cemetery		23d. LOCATION CITY OR TOWN Brentwood	STATE P.G. Maryland
24. FUNERAL DIRECTOR NAME F. Gasch's Sons F.H. P.A. Hyattsville, Maryland		ADDRESS		25a. DATE REC'D. BY REGISTRAR APR 14 1986		
25b. REGISTRAR'S SIGNATURE						

100% of time

monday

friday

solid

soft

value of sample contains

100% of time spent in office

USB drive

100% from breathing room
100% breathing room

100% from mouth

breath of living room 100% and placed

00-05069

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 1 2 3 1 6

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)				FIRST Betty	MIDDLE W.	LAST Murphy	2a. DATE OF DEATH MONTH May	MONTH DAY	DAY 4	YEAR 27	YEAR 86	2b. HOUR 5:05 P.M.	
3. SEX Female		4. RACE Caucasian		5. DATE OF BIRTH MONTH May		DAY 3	YEAR 1925	6. AGE (IN YEARS LAST BIRTHDAY) YRS 60		IF UNDER 1 YEAR MONTHS 0		IF UNDER 24 HRS HOURS 0	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) North Carolina		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince George							
10. CITY OR TOWN OF DEATH Clinton		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Southern Maryland Hospital Center		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Government-Ret.		12b. KIND OF BUSINESS OR INDUSTRY Fed. Gov't.							
13a. STATE Maryland		13b. COUNTY Montgomery	13c. CITY OR TOWN Silver Spring	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 10220 Leslie St. 20902							
14. FATHER'S NAME FIRST Lonnie		MIDDLE 	LAST West	15. MOTHER'S MAIDEN NAME FIRST Madeline		MIDDLE 	LAST Murray						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 237-34-9993		17. INFORMANT Barbara J. Green		ADDRESS Route 1, Box 272 Marbury, Md.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last		DUE TO, OR AS A CONSEQUENCE OF (b) Gram negative sepsis		DUE TO, OR AS A CONSEQUENCE OF (c) Adenocarcinoma of Duodenum		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 Gastrointestinal obstruction													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN	COUNTY	STATE					
22a. I certify that (1) this hospital attended the deceased from 4/18 , 19 86 , to 4/22 , 19 86 , that (2) the last saw the deceased alive on 4/27 , 19 86 , and that in (my) opinion death occurred on the date and hour and from the causes stated above. (I certify that did not view the body after death.)													
22b. PHYSICIAN'S NAME (TYPE OR PRINT) R. A. McConaughy, M.D.		22c. DEGREE M.D.		ATTENDING PHYSICIAN <input type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22d. DATE SIGNED 4-28-86							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 4/30/86		23c. NAME OF CEMETERY OR CREMATORIAL Trinity Memorial Gardens		23d. LOCATION CITY OR TOWN Waldorf COUNTY Charles STATE Maryland							
24. FUNERAL DIRECTOR NAME George P. Kalas Funeral Home		25a. DATE REC'D. BY REGISTRAR ADDRESS 6160 Oxon Hill Rd. Oxon Hill, Md.		25b. REGISTRAR'S SIGNATURE Johanna Daviden		25c. DATE REC'D. BY REGISTRAR APR 29 1986							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

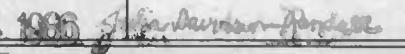
IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 and 2 should be filed with the burial permit. Then please remove the burial permit and file with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 2 is marked on Item 8 showing injury, or other circumstances, in his medical examination report, it should be filed on one of the following pages.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 8 0 1 2 3 1 7	
1. DECEASED NAME (TYPE OR PRINT)			FIRST CONRAD	MIDDLE S.	LAST MUSGROVE	2a. DATE OF DEATH MONTH 4	MONTH 12	DAY 86	YEAR	2b. HOUR 10 45PM	
3. SEX Male		4. RACE Black		5. DATE OF BIRTH MONTH 5		DAY 12	YEAR 45	6. AGE (IN YEARS LAST BIRTHDAY) YRS 40		IF UNDER 1 YEAR MONTHS DAYS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington, D.C.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGE COUNTY		10. IF UNDER 24 HRS. MONTHS DAYS		11. IF UNDER 24 HRS. HOURS MIN.	
10. CITY OR TOWN OF DEATH CHEVERLY		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) PRINCE GEORGE GENERAL HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Auto Interior Repair Upholstery		12b. KIND OF BUSINESS OR INDUSTRY Capitol					
13a. STATE M.D.		13b. COUNTY P.G.		13c. CITY OR TOWN Capitol Heights		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 4601 Southern Avenue 20743			
14. FATHER'S NAME FIRST William		MIDDLE 	LAST Musgrove	15. MOTHER'S MAIDEN NAME FIRST Rebecca		MIDDLE 	LAST Strother				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 578-57-3889		17. INFORMANT Jeanette Blake		18. ADDRESS 4321 Hayes Street, N.E. Washington, D.C. 20019		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
18. CAUSE OF DEATH (ENTER ONLY ONE CAUSE PER LINE FOR 10, 1b, AND c) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIAC ARREST											
DUE TO, OR AS A CONSEQUENCE OF (b) IRREVERSIBLE Shock + BRADYCARDIA											
DUE TO, OR AS A CONSEQUENCE OF (c) _____											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a Hepatic Encephalopathy											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE 		22c. DEGREE MD		22d. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22e. DATE SIGNED 4/14/86					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 4/18/86		23c. NAME OF CEMETERY OR CREMATORIAL Harmony Memorial Park		23d. LOCATION CITY OR TOWN Landover		COUNTY Prince George's MD		STATE	
24. FUNERAL DIRECTOR NAME ROLLINS FUNERAL HOME, INC.		ADDRESS 4339 HUNT PLACE, N.E.		25a. DATE REC'D. BY REGISTRAR APR 21 1986		25b. REGISTRAR'S SIGNATURE 					
WASHINGTON, D.C. 20019											

7

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please have the entire certificate filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other disposition. If item 18 shows any injury, or other information which the medical examiner must be notified of, page 4 may be used.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 6 1 2 3 1 8					
										REG. NO.					
1 - STATE REGISTRAR			1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a DATE OF DEATH MONTH DAY YEAR			2b HOUR			
			LINDSEY B. NEAL						04 09 86			8 35PM			
3 SEX			4. RACE			5 DATE OF BIRTH MONTH DAY YEAR			6 AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
Male			Black			March 24, 1909			77 YRS						
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH			PRINCE GEORGE'S COUNTY MD.			
10 CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY						
CHEVERLY			PRINCE GEORGE'S GENERAL HOSPITAL			Mail Room Super. Advertising									
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)										13e STREET ADDRESS / ZIP CODE					
13a STATE			13b COUNTY			13c CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e STREET ADDRESS / ZIP CODE			
Maryland			Pr. Georges			N. Englewood						1512 Jutewood Ave. 20785			
14 FATHER'S NAME FIRST MIDDLE LAST						15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST									
George W. Neal						Anna Fauver									
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b SOCIAL SECURITY NO			17 INFORMANT			ADDRESS			North Englewood, Md.			
Yes WW II						Isabelle B. Neal, 1512 Jutewood Ave,									
18 CAUSE OF DEATH (Enter only one cause per line for 18, 18b and 18c) PART I. DEATH WAS CAUSED BY										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
IMMEDIATE CAUSE (a) Brian Absent										Brief Fct					
DUE TO, OR AS A CONSEQUENCE OF (b) Leprosy Shock										11 "					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) Asymptomatic Pneumonia										12 "					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Hepatitis - Renal Failure															
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that (I) (this hospital) attended the deceased from 2-1-1986 to 19 to 19, that (II) (we) last saw the deceased alive on 2-9-1986 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (II) (we) (did) (did not) view the body after death.															
22b. SIGNATURE DEGREE										22c. DATE SIGNED 4.9.86					
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>									
CHANNESS SAHAKIAN			5632 Annapolis Rd., Bladensburg MD												
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE 4/14/86			23c. NAME OF CEMETERY OR CREMATORIAL Lincoln Memorial Cem.			23d. LOCATION CITY OR TOWN Suitland, Maryland			23e. COUNTY STATE			
Burial															
24. FUNERAL DIRECTOR NAME			ADDRESS			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE						
McGuire Funeral Serv.			Washington, DC			APR 18 1986			Julia L. Anderson						
(VRA 15, 4)															

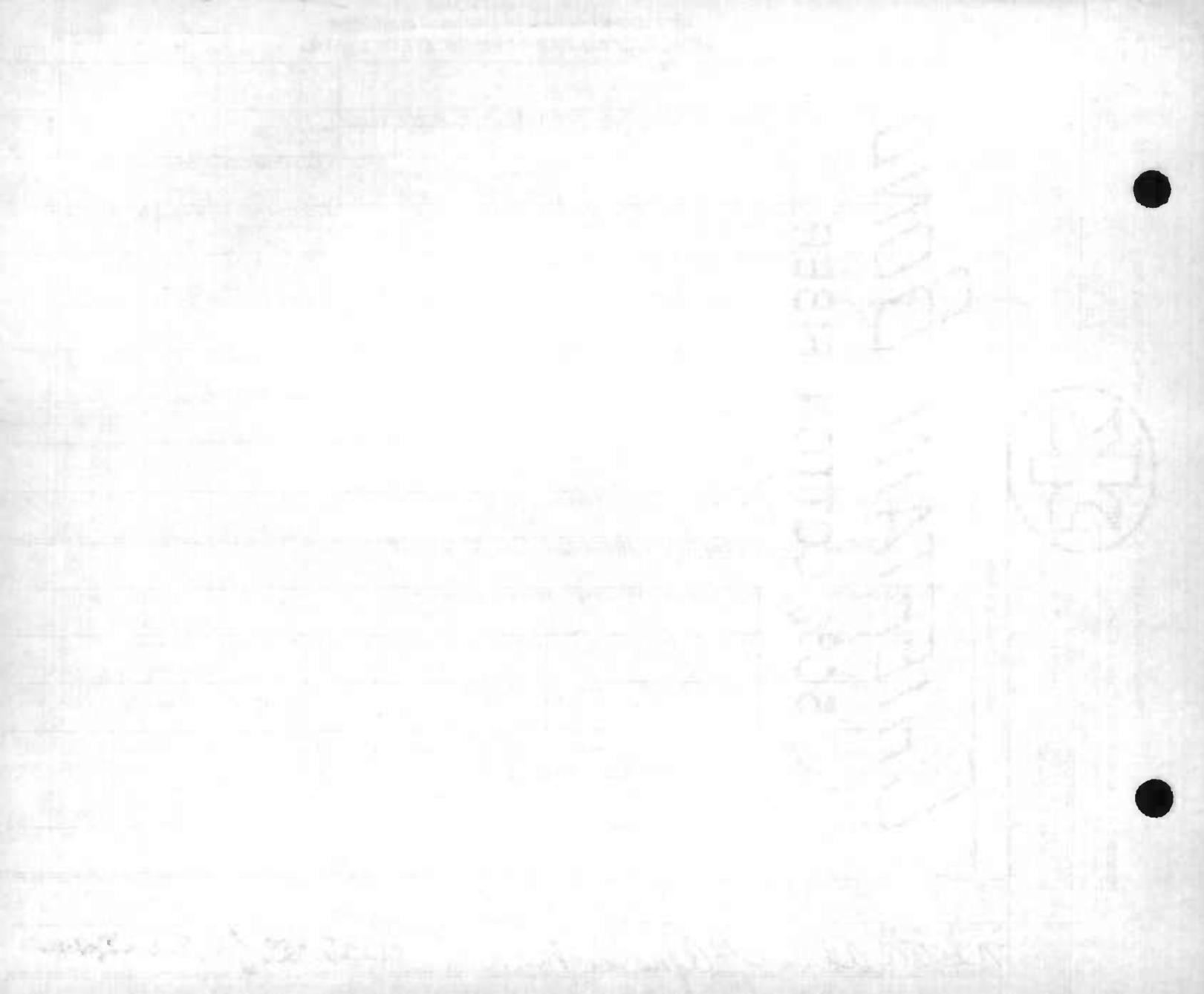
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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3 RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND. 201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO. 12319						
1- STATE REGISTRAR			1. DECEASED NAME (TYPE OR PRINT)			FIRST			MIDDLE			LAST			2a. DATE KNOWN OF ESTI. DEATH MATED	2b. MONTH	2b. DAY	2b. YEAR
			Hilda			D.			Nelson						<input checked="" type="checkbox"/>			
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			7. IF UNDER 1 YR.		8. IF UNDER 24 HRS.		2c. DATE PRONOUNCED DEAD	2d. MONTH	2d. DAY	2d. YEAR	
Female		Black		2 20 '18 68			YRS.			MONTHS	DAYS	HOURS	MIN	4/21/86	24 HOUR	3:36	P M	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED			9. BALTIMORE CITY OR COUNTY OF DEATH			Prince George's County, MD.								
Maryland		USA																
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)										12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY			
Clinton		Southern Maryland Medical Center										Homemaker			Domestic			
13a. STATE		13b. COUNTY		13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS									
Maryland		Prince Geo		Brandywine					5303 Accokeek Road 20613									
14. FATHER'S NAME		FIRST		MIDDLE		LAST		15. MOTHER'S MAIDEN NAME		FIRST		MIDDLE		LAST				
Oscar						Duckett		Victorine						Mahoney				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO		16b. SOCIAL SECURITY NO.		16c. ADDRESS		17. INFORMANT		2302 Pinewood Ave.										
(If Yes, give war or dates) N/A		214 14 8619		Doris Rhames Baltimore Md. 21214														
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: 815/ IMMEDIATE CAUSE (a) Traumatic Dissecting Aortic Aneurysm Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c) DUE TO, OR AS A CONSEQUENCE OF															APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)																		
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?										20. AUTOPSY?					
													<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO					
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR <input checked="" type="checkbox"/> AM. MONTH DAY YEAR			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			passenger in auto/fixed object collision									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY STATE						
			roadway						Rt. #5 Southbound, Clinton, Pr. Geo., Md.									
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>															Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion			
ACTUAL SIGNATURE															TITLE (SPECIFY)			
															M.D. Assistant MEDICAL EXAMINER			
EXAMINER'S NAME (TYPE OR PRINT)															DATE SIGNED 4/22/86			
Gregory R. Kauffman, M.D.			ADDRESS 111 Penn St.															
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION CITY OR TOWN			COUNTY STATE						
Burial			26 April 186			Asbury UMC Cem			Brandywine P.G. Md.									
24. FUNERAL DIRECTOR NAME			ADDRESS Martell Adams, Aquasco Md.						25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE						
									May 12 1986			John K. Kauffman						
DHMH - 17 (VR A15 ME (5))																		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be referred by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked Item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					REG. NO. 8012320
1 - FOR STATE REGISTRAR	FIRST Beret	MIDDLE Toline	LAST Neumann	2a DATE OF DEATH April 29, 1986	MONTH DAY YEAR 2b HOUR 5:35A.M.
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH August DAY 18 YEAR 1897	6 AGE (IN YEARS LAST BIRTHDAY) 88	IF UNDER 1 YEAR MONTHS YRS.	IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Illinois	7b CITIZEN OF WHAT COUNTRY? U.S.A.	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9 BALTIMORE CITY OR COUNTY OF DEATH Prince George's County MD.		
CITY OR TOWN OF DEATH Lanham	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Doctor's Hospital of Pr. Geo. Co.			12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker	12b KIND OF BUSINESS OR INDUSTRY Own Home
13a STATE Maryland	13b COUNTY P.G.	13c CITY OR TOWN Greenbelt	13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e STREET ADDRESS / ZIP CODE 60-H Crescent Road 20770	
14 FATHER'S NAME FIRST Thomas	MIDDLE	LAST Hanson	15 MOTHER'S MAIDEN NAME FIRST Betsy	MIDDLE	LAST Clevon
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No	16b SOCIAL SECURITY NO. 352-10-6341	17. INFORMANT George Neumann (Son)	18 ADDRESS Lakeside Drive Greenbelt, Md. 20770	APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 week	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRAL INFARCTION DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO, OR AS A CONSEQUENCE OF (c)					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)					
19a DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)	21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f LOCATION STREET	CITY OR TOWN	COUNTY	STATE
22a I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 4/22/86 , 19 86 , to 4/29 , 19 86 , that <input checked="" type="checkbox"/> (I) (we) lost saw the deceased alive on 4/28/86 , 19 86 , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (did) and did not view the body after death.					
22b SIGNATURE Robert Gerwin M.D.			DEGREE	ATTENDING PHYSICIAN <input checked="" type="checkbox"/>	MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>
22d PHYSICIAN'S NAME (TYPE OR PRINT) Robert D. Gerwin, M.D.			22e ADDRESS 14300 Gallant Fox Lane - Bowie, Maryland	22f. DATE SIGNED Apr. 29, 1986	
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b DATE 5/1/86	23c NAME OF CEMETERY OR CREMATORIAL Fort Lincoln Cemetery	23d LOCATION CITY OR TOWN Brentwood	COUNTY P.G.	STATE Maryland
24 FUNERAL DIRECTOR NAME F. Gasch's Sons F.H. P.A. Hyattsville, Md.			25a DATE REC'D. BY REGISTRAR MAY 1 1986	25b. REGISTRAR'S SIGNATURE Julia Gerwin Gerwin	
DHMH - 16 60M 7/84 (VRA 15, 4)					

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO. 8012321			
1 - STATE REGISTRAR			1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR			
			Bertha P. Newman						April 2, 1986			8:15A M			
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR IF UNDER 24 HRS			
Female			Black			Sept. 24, 1904			81			MONTHS DAYS HOURS MIN.			
YRS.															
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH						
Florida			USA						Prince Georges County						
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY						
Laurel			Greater Laurel Beltsville Hospital			Housewife									
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?			13e. STREET ADDRESS / ZIP CODE			
MD			Pr. Geo			Laurel			YES <input type="checkbox"/> NO <input type="checkbox"/>			100 9th Street/ 20707			
14. FATHER'S NAME			FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME									
Jeff Peterson						Fannie Randall									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS						
No			265-40-6003			Freddie Newman (son) same as #13									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.												48 hours			
{ DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerosis Cardiomyopathy												year			
{ DUE TO, OR AS A CONSEQUENCE OF (c) Upper Anterior Myocardial Ischemic Process															
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)															
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?						
									YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)									
			P.M. 19												
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY STATE			
22a. I certify that (I) (Not Hospital) attended the deceased from March 19 86 to April 19 86, that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (Not Hospital) did not view the body after death.															
22b. SIGNATURE			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED						
Dennis R. Schuner M.D.												4/2/86			
THE PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS												
Dennis R. Schuner M.D.			14201 Laurel Park Lane #102 20707												
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN			COUNTY STATE			
Burial			4-5-86			Mt. Zion Cemetery			Laurel, Anne Ar.			MD			
24. FUNERAL DIRECTOR NAME			246 N. Washington			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE						
George R. Snowden			Rockville, MD 20850			APR 7 1986			Julie Snowden-Arden						

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TO HOSPITAL OR ATTENDING PHYSICIAN: This law requires that the death certificate be executed within 24 hours after death, unless otherwise directed.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

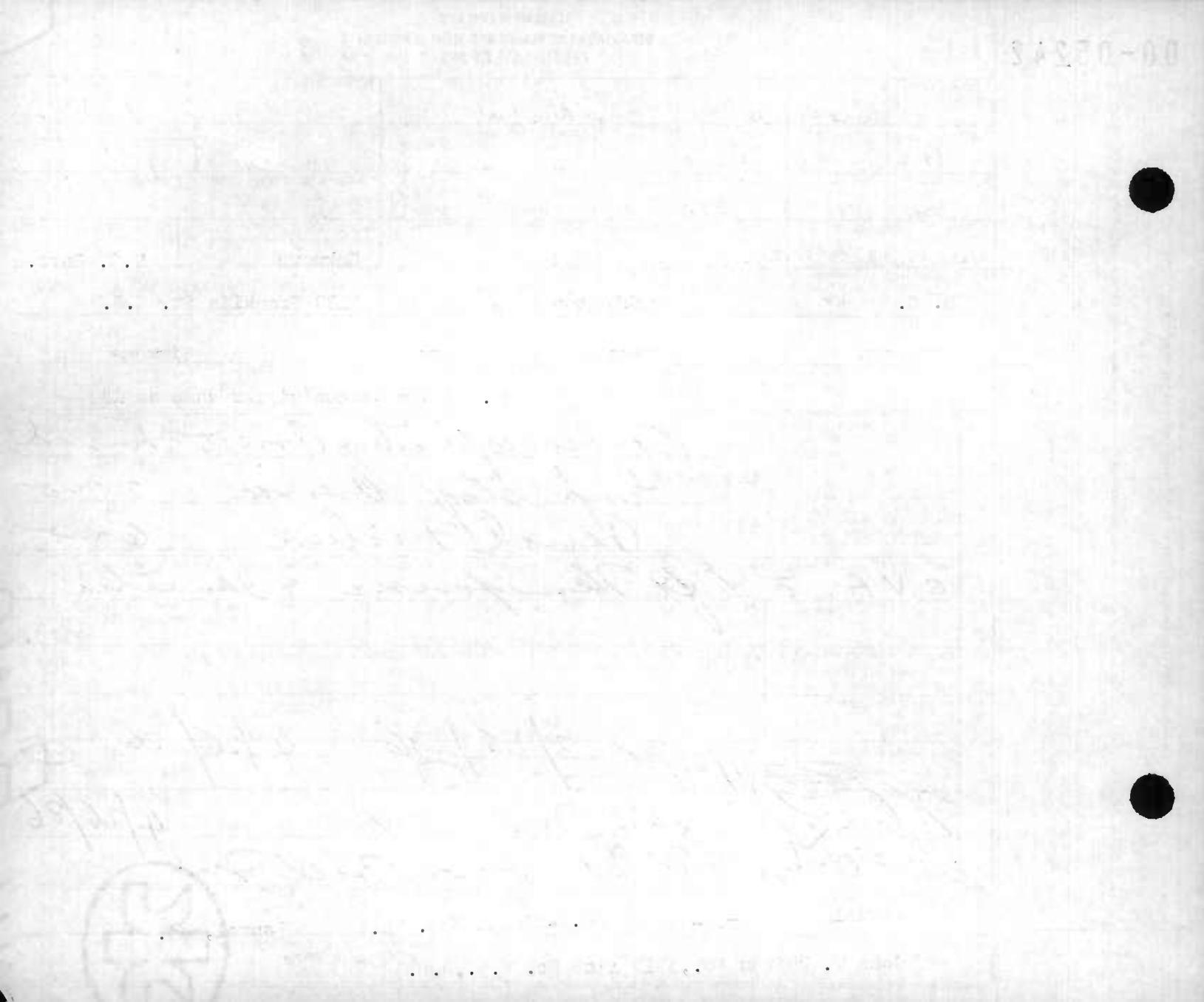
IMPORTANT: If item 23 is marked or if item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

1. FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 80 | 2322

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	20. DATE OF DEATH	MONTH	DAY	YEAR	26. HOUR	
Cornelius					Newton	4	26	86	720 PM		
3. SEX	4. RACE	5. DATE OF BIRTH	MONTH	DAY	YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR	IF UNDER 24 HRS			
m.	Black	12	19	25		60	YRS	MONTHS	DAYS	HOURS	MIN.
7a. BIRTHPLACE (COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH P.G.						MD.		
Wash. D.C.	USA										
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Unknown						12b. KIND OF BUSINESS OR INDUSTRY U.S. Govt.		
Forestview, Md.	Regency Hosp. Home										
13a. STATE D. C.	13b. COUNTY	13c. CITY OR TOWN Washington	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 2120 Franklin St. N.E.						
14. FATHER'S NAME FIRST Namaman			15. MOTHER'S MAIDEN NAME FIRST Mary		MIDDLE		LAST Simmons				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO. 217147454		17. INFORMANT Ms. Odessa Newton/sister/same as 13e		ADDRESS				
18. CAUSE OF DEATH: Enter only one cause per line for items 1b, 1c and 1d - PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)			Conditions, if any, which gave rise to immediate cause (b) stating the underlying cause lost.		DUE TO, OR AS A CONSEQUENCE OF (b)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Sunned,				
					DUE TO, OR AS A CONSEQUENCE OF (c)		2 mo				
					DUE TO, OR AS A CONSEQUENCE OF (d)		6 mo				
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1b: C.V.A. c left hemiparesis & dementia											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING: <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (BY EITHER HOSPITAL MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> INC. WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET		CITY OR TOWN	COUNTY	STATE		
22a. I certify that (I) (this hospital) attended the deceased from <u>4/26/86</u> to <u>4/26/86</u> , to whom he was admitted on <u>4/26/86</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) have had no visit to the body after death.											
22b. SIGNATURE <u>John T. Rhines Co.</u>					DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		27. DATE SIGNED 4/26/86				
22c. PHYSICIAN'S NAME (TYPE OR PRINT) John T. Rhines Co.		22d. ADDRESS Oxon Hill Ind									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 4-30-86		23c. NAME OF CEMETERY OR CREMATORIAL Md. National Mem. Pk.		23d. LOCATION Laurel, Md.		23e. COUNTY			
24. FUNERAL DIRECTOR NAME John T. Rhines Co., 3015 12th St. N.E., D.C.		ADDRESS 12th St. N.E., D.C.		25a. DATE REC'D. BY REGISTRAR APR 30 1986		25b. REGISTRAR'S SIGNATURE					

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IN PENCIL IN ITEM 8, GIVE PAGES 1 & 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER FOR PAGES 1 & 2, AND 3 TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRUST PERMIT. PAGES 1 & 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, Cremation, or Removal.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG NO. 12323	
1 - STATE REGISTRAR				FIRST MIDDLE LAST Granville R Nichols									
1a. DECEASED NAME (TYPE OR PRINT)				2a. DATE KNOWN OF ESTI- DEATH MATED		MONTH DAY YEAR		2b. HOUR		2c. HOUR			
3. SEX Male		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS) LAST BIRTHDAY		IF UNDER 1 YR. MONTHS DAYS HOURS MIN		7. DATE PRONOUNCED DEAD MONTH DAY YEAR			
7d. BIRTHPLACE (STATE OR FOREIGN COUNTRY) West Virginia		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's		MD.			
10. CITY OR TOWN OF DEATH Columbia				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) P.O. Doctors Hosp				12a. USUAL OCCUPATION (TYPE OF WORK) FOR MOST OF WORKING LIFE Mech Engineer		12b. KIND OF BUSINESS OR INDUSTRY NASA			
13a. STATE Md				13b. COUNTY Pr Geo		13c. CITY OR TOWN Ft. Washington		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 4623 Penn St. 20744			
14. FATHER'S NAME FIRST Roland				MIDDLE Nichols		15. MOTHER'S MAIDEN NAME FIRST Minnie		MIDDLE		LAST Cline			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yes Korean				16b. SOCIAL SECURITY NO. 735 46 7875		17. INFORMANT Martha M Nichols		ADDRESS Same as #13					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>An acute myocardial dis.</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a). <i>None</i>													
19a. DATE OF OPERATION <i>None</i>				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET		CITY OR TOWN		COUNTY	STATE
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>													
ACTUAL SIGNATURE <i>John S. Rogers</i> TITLE (SPECIFY) M.D. <i>Doyle</i> MEDICAL EXAMINER												DATE SIGNED <i>Apr 17 1986</i>	
EXAMINER'S NAME (TYPE OR PRINT) John S. Rogers				ADDRESS 1919 Seminary Rd Sil Sp Md									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 21 April 186		23c. NAME OF CEMETERY OR CREMATORIAL Washington National				23d. LOCATION CITY STATE Suitland		COUNTY Maryland	
24. FUNERAL DIRECTOR NAME Robert E Wilhelm Funeral Home				ADDRESS Suitland Maryland		25a. DATE REC'D. BY REGISTRAR APR 22 1986				25b. REGISTRAR'S SIGNATURE <i>John S. Rogers</i>			
DHMH - 17 (VR A15 ME (5))													

00-04039

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in, file the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH														
REG. NO. 60 12324														
1. FOR STATE REGISTRAR			2a. DECEASED NAME (TYPE OR PRINT)			LAST			2b. DATE OF DEATH MONTH DAY YEAR					
VICTOR Woodrow NICHOLAS SR.									4 15 86					
3. SEX male			4. RACE caucasian			5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY) IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.					
7a. BIRTHPLACE COUNTRY West Virginia			7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's MD.					
10. CITY OR TOWN OF DEATH Laurel			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Greater Laurel Beltsville Hosp.			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Guid. Counselor School			12b. KIND OF BUSINESS OR INDUSTRY					
13a. STATE Md.			13b. COUNTY P.G.			13c. CITY OR TOWN Laurel			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE 6213 Kaybro St. 20707		
14. FATHER'S NAME FIRST Kazen			MIDDLE LAST Nicholas			15. MOTHER'S MAIDEN NAME FIRST Buelah			MIDDLE LAST Damous					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO. (IF YES, GIVE MARSHAL DATES) WWII			17. INFORMANT Victor Nicholas, Jr.			ADDRESS same as 13e					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) LIVER FAILURE APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 mo														
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) METASTATIC COLON CANCER 6 yrs														
DUE TO, OR AS A CONSEQUENCE OF (c)														
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)														
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (the hospital) attended the deceased from 9/12, 19 86, to 9/15 19 86, that (I) (we) lost saw the deceased alive on 9/14 19 86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If deceased did not die in hospital, check here) _____														
22b. SIGNATURE R. MAGGIN			DEGREE MD			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 4/15/86					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE 4/18/86			23c. NAME OF CEMETERY OR CREMATORIAL Meadowridge Meom.Pk. Balto.			23d. LOCATION CITY OR TOWN COUNTY STATE					
Burial			4/18/86			Meadowridge Meom.Pk. Balto.			Balto. Md.					
24. FUNERAL DIRECTOR NAME FIECH F.H. Inc.			25a. DATE REC'D. BY REGISTRAR APR 18 1986			25b. REGISTRAR'S SIGNATURE J. J. JONES								

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours
referred by the Hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial permit. Then please remove carbon paper. Forms 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial; cremation; or repatriation.
IMPORTANT: If Item 21 is marked as having died from injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO. 8 0 1 2 3 2 5	
1 - STATE REGISTRAR			1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2d. DATE OF DEATH MONTH DAY YEAR			2b. HOUR	
			SUSAN L NISH						APR 11 86			5:05pm	
3. SEX			4. RACE			5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR	
Female			Caucasian			April 19, 1953			32			MONTHS DAYS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Mass.			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's			IF UNDER 24 HRS. MONTHS HOURS MIN.	
10. CITY OR TOWN OF DEATH Camp Springs			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Malcolm Grow Medical Cen. AAFB			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Dental Assistant			12b. KIND OF BUSINESS OR INDUSTRY Private				
13a. STATE Maryland			13b. COUNTY P.G.			13c. CITY OR TOWN Ft. Washington			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE 1820 Taylor Ave. 20744	
14. FATHER'S NAME FIRST MIDDLE LAST Robert			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Leona Willett										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 1972-1983			17. INFORMANT John E. Nish			ADDRESS Same as 13 A-E				
18. CAUSE OF DEATH (Enter only one cause per line for 18). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIO PULMONARY ARREST</u>												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) <u>Sepsis</u>													
DUE TO, OR AS A CONSEQUENCE OF (c)													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED <input type="checkbox"/> AT HOME <input type="checkbox"/> NOT WHILE AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN COUNTY STATE				
22a. I certify that <input type="checkbox"/> (this hospital) attended the deceased from <u>14 Feb</u> , 19 <u>86</u> , to <u>11 April 86</u> , 19 <u>86</u> , that <input type="checkbox"/> (we) lost saw the deceased alive on <u>11 April 19 86</u> , and that in <input type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, <input type="checkbox"/> (we) did <input type="checkbox"/> did not view the body after death.													
22b. SIGNATURE <u>Timothy H. Ladner</u>			22c. DEGREE MD			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22d. DATE SIGNED				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) TIMOTHY H. LADNER			22e. ADDRESS MALCOLM GROW MEDICAL CENTER ANDREWS AFB MD 20331-5300										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation			23b. DATE 04/15/1986			23c. NAME OF CEMETERY OR CREMATORIAL Lees Crematory			23d. LOCATION CITY OR TOWN Clinton			COUNTY P. G. Maryland STATE	
24. FUNERAL DIRECTOR NAME Lee Funeral Home, Inc. ADDRESS 6633 Old Alexander Ferry Rd Clinton, Md 20735						25a. DATE REC'D. BY REGISTRAR APR 17 1986			25b. REGISTRAR'S SIGNATURE <u>Julia Dawson-Gardella</u>				

91883-10

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

RECORDED IN

BP _____

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-trust permit. Then please remove seal and file with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or if item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO. 8012326						
1. FOR STATE REGISTRAR			I. DECEASED NAME (TYPE OR PRINT)			FIRST Ruby			MIDDLE Nolan			2a. DATE OF DEATH MONTH April 14, 1986			2b. HOUR 7:15 am			
3. SEX Female			4. RACE White			5. DATE OF BIRTH MONTH 7			DAY 16			YEAR 92			6. AGE (IN YEARS LAST BIRTHDAY) 93 YRS			
															IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland			7b. CITIZEN OF WHAT COUNTRY? U.S.			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Prince Georges County MD.									
10. CITY OR TOWN OF DEATH Laurel			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Greater Laurel-Bethesda Hospital			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Manager			12b. KIND OF BUSINESS OR INDUSTRY Plastic									
13a. STATE Md.			13b. COUNTY Montgomery			13c. CITY OR TOWN Bethesda			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE 10307 Cheshire Terrace 20014						
14. FATHER'S NAME First Martin			Middle L.			Last Yngts			15. MOTHER'S MAIDEN NAME First Minnie			Middle F.			Last Waters			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. 103-20-8580			17. INFORMANT Mrs. Thora Motyka Bethesda, Md.			18. ADDRESS Cheshire Terr. 10307						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>SENILITY.</u>																		
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b)																		
DUE TO, OR AS A CONSEQUENCE OF (c)																		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 <u>DECUBITI ULCERS.</u>																		
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>									
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)												
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from <u>2/06/86</u> , to <u>4/12/86</u> , 1986, that (I) (we) last saw the deceased alive on <u>19</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																		
22b. SIGNATURE <u>Dr. Reffem</u>			22c. DEGREE 811			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22d. DATE SIGNED <u>4/14/86</u>									
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS															
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Removal			23b. DATE 4-15-86			23c. NAME OF CEMETERY OR CREMATORIAL Balto., Md.			23d. LOCATION CITY OR TOWN			COUNTY STATE						
24. FUNERAL DIRECTOR NAME Anatomy Board			25a. DATE REC'D. BY REGISTRAR APR 22 1986			25b. REGISTRAR'S SIGNATURE <u>Julie Dawson-Randall</u>												
DHMH - 16 50M 4/83 (VRA 15, 4)																		

(1)

TO HOSPITAL OR ATTENDING PHYSICIAN: The retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached to use as the burial permit. Then please remove carbon papers. Pages 1 and 2 may be filed within 22 hours after death.

with the State Dept. of Health and Mental Hygiene prior to entry, certification, or removal.

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MEDICAL CERTIFICATION

**1 - FOR
STATE
REGISTRAR**

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 0 1 2 3 2 7
REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR			
Anna M Noonan						April 11	6, 1986			8:40A M			
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR 72 18 1890		6. AGE (IN YEARS LAST BIRTHDAY) 95		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.			
7a. BIRTHPLACE COUNTRY MARYLAND		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's County MD.							
10. CITY OR TOWN OF DEATH LAUREL		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Greater Laurel Beltsville Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) CLERK		12b. KIND OF BUSINESS OR INDUSTRY U.S. GOV'T.							
13a. STATE MARYLAND						13b. COUNTY PRINCE GEO.		13c. CITY OR TOWN LAUREL		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 243 ROCKBRIDGE ROAD 20707	
14. FATHER'S NAME FIRST SAMUEL			MIDDLE S	LAST KEMP	15. MOTHER'S MAIDEN NAME FIRST ELIZABETH		MIDDLE	LAST WELCH					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO			16b. SOCIAL SECURITY NO. 217-52-6564			17. INFORMANT JAMES NOONAN 4809 TOPPING ROAD		ADDRESS ROCKVILLE, MARYLAND 20852					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Respiratory Failure</i>						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>one hour</i>							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ (c) _____													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>Malnutrition</i>													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE			
22a. I certify that (I) (this hospital) attended the deceased from JULY 24, 1979 , to APRIL 6, 1986 , that (I) (we) last saw the deceased alive on APRIL 5, 1986 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE <i>Robert Ammlung</i>		DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 4/6/86							
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DR. ROBERT AMMLUNG M.D.		22e. ADDRESS 321 PRINCE GEORGE STREET LAUREL, MD. 20707											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 04-09-1986		23c. NAME OF CEMETERY OR CREMATORIUM FORT LINCOLN CEMETERY		23d. LOCATION CITY OR TOWN BRENTWOOD		COUNTY PRINCE GEO.		STATE MARYLAND			
24. FUNERAL DIRECTOR NAME FRANCIS J. COLLINS, JR.		ADDRESS 500 UNIVERSITY BLVD. WEST SILVER SPRING, MD.		25a. DATE REC'D. BY REGISTRAR APR 10 1986		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>							

CS507-10



00-04672

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PAPER IN PAGE 4. SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER OR FUNERAL DIRECTOR. PAGE 3 SHOULD BE USED AS A BURIAL TRAVEL PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84
25MBP _____
DHMH - 17
(VR A15 ME (5))

1- STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

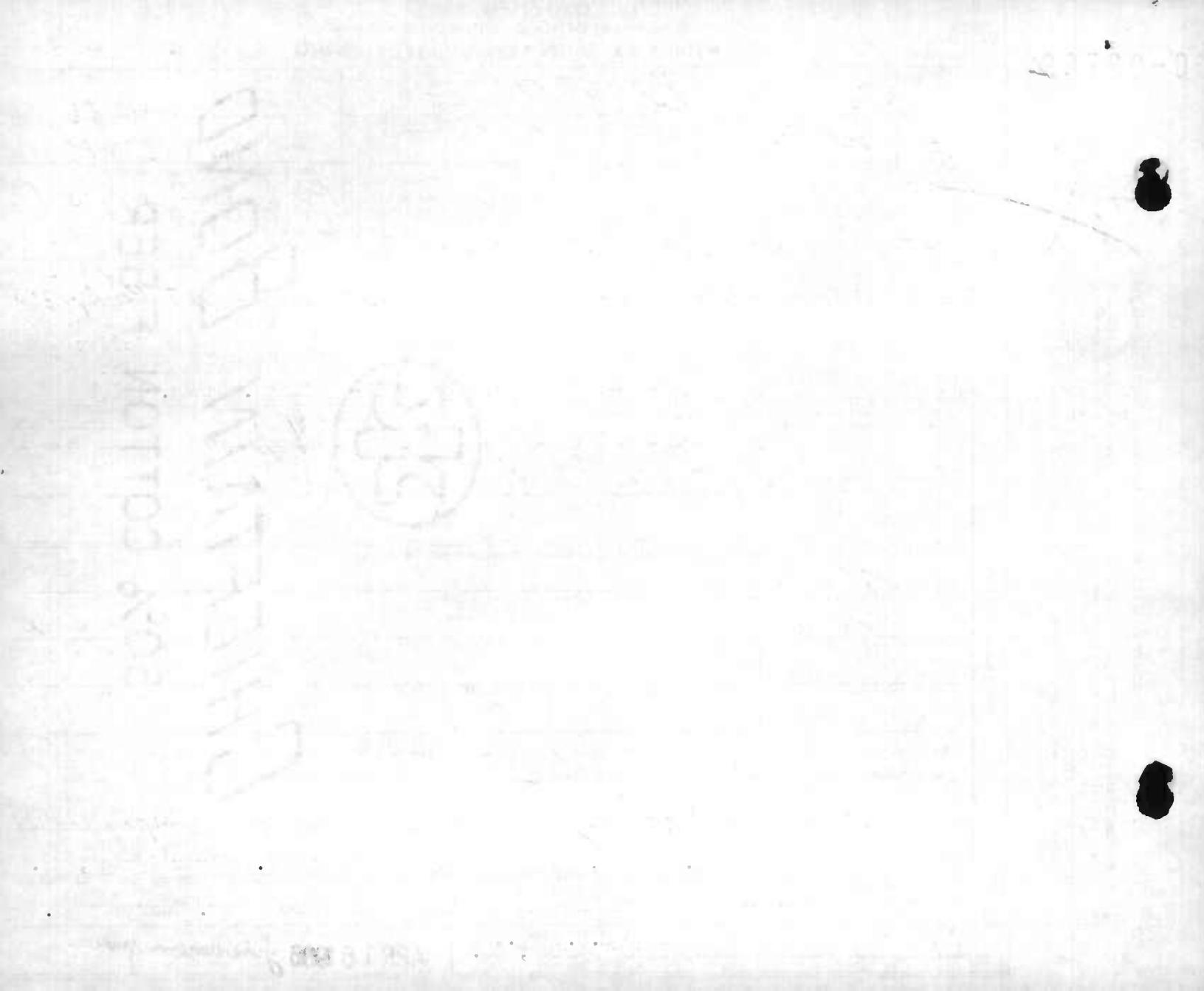
REG. NO. 2328

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a DATE KNOWN OF ESTI- DEATH MATED	MONTH	DAY	YEAR	2b. HOUR
<i>John Edward Oden</i>						<i>4-13-86</i>				
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	7. IF UNDER 1 YR. MONTHS DAYS	8. IF UNDER 24 HRS. HOURS MIN.	2c. DATE PRONOUNCED DEAD	MONTH	DAY	YEAR	2d. HOUR
<i>Male</i>	<i>White</i>	<i>July 12 08</i>	<i>77</i>			<i>4-12-86</i>				
7a. BIRTHPLACE (STATE OR COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Prince George's</i>			
<i>Washington DC</i>		<i>USA</i>								
10. CITY OR TOWN OF DEATH <i>Berwynne</i>			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>2901 Upland Avenue</i>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Engineer</i>			12b. KIND OF BUSINESS OR INDUSTRY <i>DC Gov't</i>	
13a. STATE <i>Maryland</i>	13b. COUNTY <i>Pr Geo</i>	13c. CITY OR TOWN <i>Berkshire</i>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <i>2901 Upland Avenue</i>					
14. FATHER'S NAME <i>Raymond</i>			MIDDLE	LAST	15. MOTHER'S MAIDEN NAME <i>Mary</i>		16. ADDRESS <i>Beltsville Md</i>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <i>NO</i>			16b. SOCIAL SECURITY NO. <i>578 62 1268</i>			17. INFORMANT <i>Raymond P Oden</i>			18. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
18. CAUSE OF DEATH (Enter only one cause of death for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last.			<i>Hypertension Cardiac vascular disease</i>							
			DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c)							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. <i>Emphysema</i>										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .										
ACTUAL SIGNATURE <i>Augusto P. Rodriguez</i>										
EXAMINER'S NAME <i>Augusto P. Rodriguez, M.D.</i> ADDRESS <i>5009 Rayburn CT, Temple Hills, MD</i>										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE <i>15 April 186</i>		23c. NAME OF CEMETERY OR CREMATORIAL <i>Cedar Hill Cemetery</i>			23d. LOCATION CITY/TOWN <i>Suitland</i> COUNTY <i>Maryland</i>			
24. FUNERAL DIRECTOR NAME		Robert E Wilhelm Funeral Home Suitland Maryland			25a. DATE PREPARED <i>APR 22 1986</i> BY REGARDLESS OF DATE OF DEATH <i>John Anderson</i>					

8

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18, GIVE PAGES 1 AND 3 TO THE FUNERAL DIRECTOR, PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM P-3, RETAIN A PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT; PAGES 1 AND 2 SHOULD BE RETAINED UNTIL 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO. 1 2 3 2 9			
1- STATE REGISTRAR			2a. DATE KNOWN OF ESTI- DEATH MATED									2b. HOUR			
1. DECEASED NAME (TYPE OR PRINT)			FIRST SALLY		DUVALL		LAST OLIVER					MONTH DAY YEAR			
2. SEX F			4 RACE W		5. DATE OF BIRTH JUNE 14 1907		6. AGE (IN YEARS LAST BIRTHDAY) 78 yrs.		IF UNDER 1 YR.		IF UNDER 24 HRS.		2c. DATE PRONOUNCED DEAD		
7a. BIRTHPLACE STATE OR Kentucky			7b. CITIZEN OF WHAT COUNTRY USA		7c. MONTH DAYS		MONTH HOURS		MIN		MONTH DAY YEAR		2d. HOUR		
11. CITY OR TOWN OF DEATH Hyattsville			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 1600 Metzer St 2nd Flpx 300									12a. USUAL OCCUPATION (TYPE OF WORK) Housewife			12b. KIND OF BUSINESS OR INDUSTRY own home
13a. STATE Maryland			13b. COUNTY Prince Georges		13c. CITY OR TOWN Hyattsville		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS 1600 Metzer St Rd Apt 300					
14. FATHER'S NAME FIRST Claude			MIDDLE		LAST Duvall		15. MOTHER'S MAIDEN NAME FIRST Mildred			MIDDLE			LAST Peffer		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) N/A			16b. SOCIAL SECURITY NO. N/A		16c. DATE OF DEATH JUNE 14 1986		17. INFORMANT (nephew) Joseph Duvall-			ADDRESS 908 Rhawn Street			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Chronic Myocardial Disease</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the <u>under-</u> <u>lying cause last.</u> (b) <i>Chronic Myocardial Disease</i> DUE TO, OR AS A CONSEQUENCE OF (c) _____															
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a). <i>None</i>															
19a. DATE OF OPERATION <i>None</i>			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?									20. AUTOPSY?			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET			CITY OR TOWN			COUNTY	STATE			
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>															
ACTUAL SIGNATURE <i>R.S. Rogers</i>		TITLE (SPECIFY) M.D. <i>Deg</i>		MEDICAL EXAMINER		DATE SIGNED <i>April 12 1986</i>									
EXAMINER'S NAME (TYPE OR PRINT) John S. Rogers, DME			ADDRESS 1919 Seminary Rd. Silver Spring, Md.												
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 4-18-1986		23c. NAME OF CEMETERY OR CREMATORIAL Fort Lincoln Cemetery			23d. LOCATION CITY OR TOWN Brentwood		COUNTY Pr. Georges		STATE Md.			
24. FUNERAL DIRECTOR NAME Hines/Rinaldi Funeral Home			ADDRESS 11800 N.H. Ave. Silver Spring, Md.		25a. DATE REC'D. BY REGISTRAR APR 16 1986			25b. REGISTRAR'S SIGNATURE <i>Juliann Anderson</i>							
DHMH - 17 BP _____ (VR A15 ME (5))															



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be detached for use as the burial permit. Then please remove carbon paper. Please attach this certificate to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked as item 18 throw any injury, or other traumatic event, the medical examiner will be notified by the hospital or attending physician.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH																			
8 6 1 2 3 3 0 REG. NO.																			
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2d. DATE OF DEATH			MONTH	DAY	YEAR	7b. HOUR							
JOHN J. O'NEIL				J	ONEIL	APR 02 1986						6:08AM							
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS							
Male		Cauc.		Oct. 27 1908			77			YRS									
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH												
New Hampshire		United States					Prince Georges MD.												
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)										12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY					
Andrews AFB		Andrews AFB Hospital										Cartographer		US Gov't					
13a. STATE Va.												13b. COUNTY Arlington		13c. CITY OR TOWN --		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 640 S. 20th St. 99999	
14. FATHER'S NAME FIRST		MIDDLE		LAST	15. MOTHER'S MAIDEN NAME FIRST			MIDDLE		LAST									
John J.				O'Neil	Eleanor					Nolan									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. WWII		16c. INFORMANT 409-54-7171 Stephen O'Neil/640 S. 20th St. ARLINGT			ADDRESS		onVA										
X 18 CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIAC FAILURE												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) CONGESTIVE HEART FAILURE																			
DUE TO, OR AS A CONSEQUENCE OF (c) CONGESTIVE Heart Failure																			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																			
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)													
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY	STATE							
X 22a. I certify that (I) (this hospital) attended the deceased from 3 mar 19 86, to 2 Apr 19 86, that (I) (we) last saw the deceased alive on 1 Apr 19 86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																			
X 22b. SIGNATURE John J. Golden D.O.												DEGREE		22c. DATE SIGNED					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) JOHN J. GOLDEN, D.O.												ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF STAFF <input type="checkbox"/> PHYSICIAN <input type="checkbox"/>							
22e. ADDRESS MGMC ANDREWS AIR FORCE BASE M.D.																			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE 4/5/86			23c. NAME OF CEMETERY OR CREMATORIAL Columbia Gardens			23d. LOCATION CITY OR TOWN			23e. COUNTY		23f. STATE					
Burial												Arlington, VA.							
24. FUNERAL DIRECTOR NAME Golden Shows Home			ADDRESS Arlington, VA			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE John Davidson-Randall										

1100-00



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial permit. Then please remove carbon leaders. Pages 1 and 2 should be filed within 72 hours after death.

IMPORTANT! If item 21 is marked as "Yes" on Part I, show any injury, or other traumatic event, the medical examiner should be notified for use on the Burial Permit. Please return to burial, cremation, or removal with the State Dept. of Health and Mental Hygiene. Please mark "No" if there was no such event.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 6 2 3 3 REG. NO.	
1. DECEASED NAME (TYPE OR PRINT)			FIRST ANTONIE	MIDDLE M	LAST OPITZ	2a. DATE OF DEATH MONTH YEAR April 28 1986	MONTH APRIL	DAY 28	YEAR 1986	2b. HOUR 1053 AM	
3. SEX Female		4. RACE Caucasian		5. DATE OF BIRTH MONTH April DAY 24 YEAR 1904		6. AGE (IN YEARS LAST BIRTHDAY) 82		IF UNDER 1 YEAR YRS. MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Berlin		7b. CITIZEN OF WHAT COUNTRY? Germany		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's					
10. CITY OR TOWN OF DEATH Camp Springs		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Malcolm Grow Hospital AAFB		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housekeeper		12b. KIND OF BUSINESS OR INDUSTRY Private					
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE Maryland		13c. COUNTY P.G.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 6011 Alan Drive 20735					
14. FATHER'S NAME FIRST Franz		MIDDLE Koppen	LAST Koppen	15. MOTHER'S MAIDEN NAME FIRST Anna		MIDDLE Profrock	LAST Profrock				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. N/A		17. INFORMANT Renate Schorsch		ADDRESS Same as 13 A-E					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIOPULMONARY ARREST DUE TO, OR AS A CONSEQUENCE OF, PNEUMONIA Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Pneumonia DUE TO, OR AS A CONSEQUENCE OF (c) CONGESTIVE HEART FAILURE Congestive Heart Failure											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (s) (this hospital) attended the deceased from 23 Apr , 19 86 , to 28 Apr , 19 86 , that (s) (we) last saw the deceased alive on 28 Apr , 19 86 , and that in (s) (our) opinion death occurred on the date and hour and from the causes stated above, (s) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Shirley R. Lockie MD		22c. DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> Doug		22d. DATE SIGNED 28 Apr 86							
22e. PHYSICIAN'S NAME (TYPE OR PRINT) Shirley R. Lockie		22f. ADDRESS MALCOLM GROW USAF MED CEN, ANDREWS AFB, MD									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 04/30/86		23c. NAME OF CEMETERY OR CREMATORIAL Lee Crematory		23d. LOCATION CITY OR TOWN Clinton		23e. COUNTY Prince George's		23f. STATE MD.	
24. FUNERAL DIRECTOR NAME Lee Funeral Home, Inc.		ADDRESS 6633 Old Alexander Ferry Rd. Clinton Md 20735		25a. DATE REC'D. BY REGISTRAR MAY 2 1986		25b. REGISTRAR'S SIGNATURE <i>Shirley R. Lockie</i>					
DHMH - 16 60M 7-84 (VRA 15, 4)											

66120-30

SWAN

DO NOT DESTROY



TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed in the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical certification section must be completed.

MEDICAL CERTIFICATION

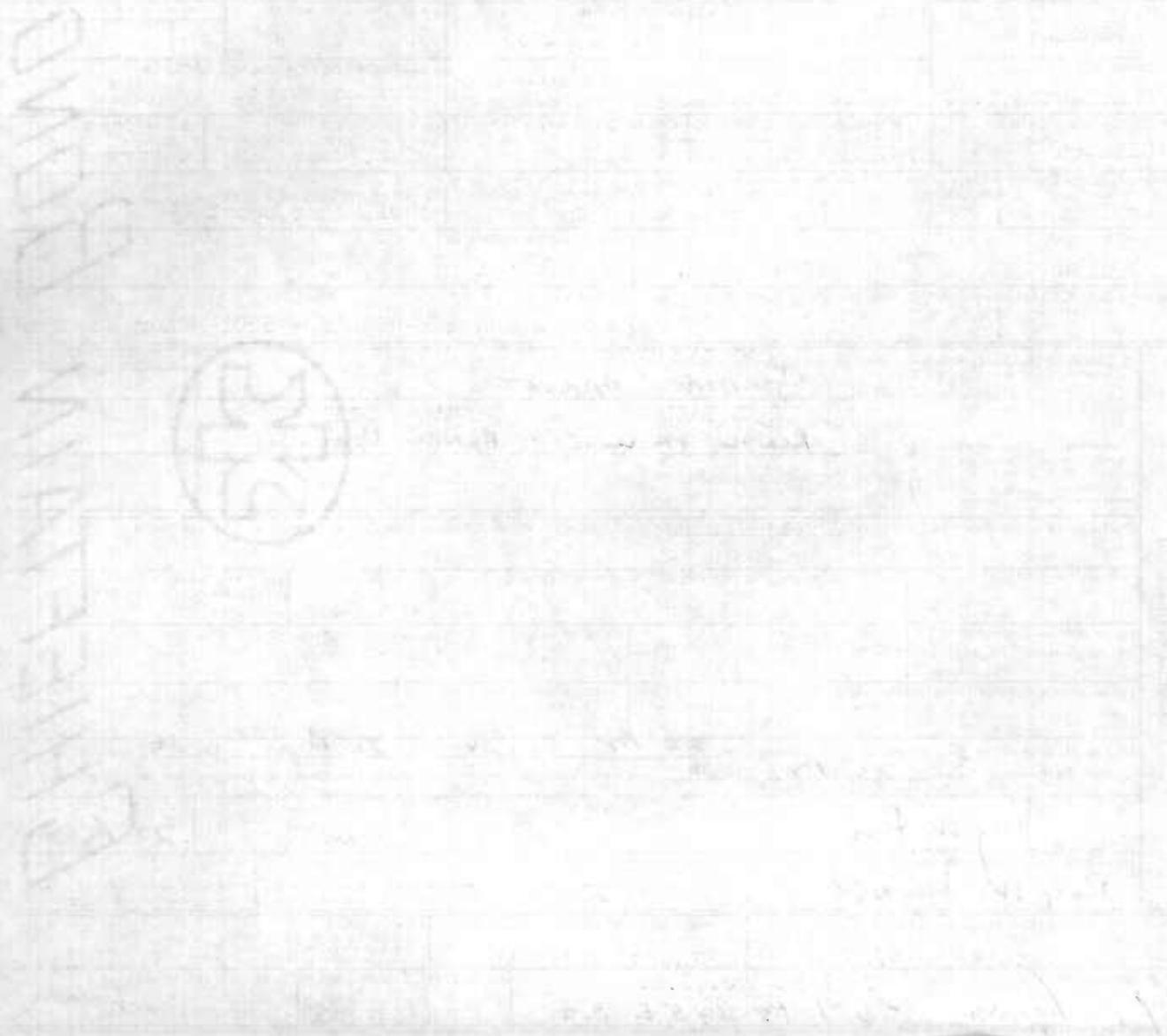
1 - STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 80 12332

1. DECEASED NAME (TYPE OR PRINT)				FIRST	MIDDLE	LAST	20. DATE OF DEATH	MONTH	DAY	YEAR	2b HOUR
JACQUELINE S OSBORNE							APR	22	86	3:45 p.m.	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS.	
FEMALE		BLACK		NOV. 3, 1935		50		MONTHS DAYS		HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8		MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH	
Charleston, S.C.		United States								Prince Georges	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY	
Clinton		MALCOLM GROW AFB HOSPITAL				Chef Cook				Government	
13a. STATE				13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS / ZIP CODE	
Maryland				PG		Oxon Hill		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		5001 Manor Court 20745	
14. FATHER'S NAME				FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME					
JOSEPH				HINES, SR.		LUCILLE					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS					
NO						ALFRED OSBORNE-HUSBAND- 5001 Manor Ct Oxon Hill Md					
18. CAUSE OF DEATH (Enter only one cause per line for Part I. Death was caused by: CARDIAC ARREST IMMEDIATE CAUSE (a) Cardiac Arrest DUE TO, OR AS A CONSEQUENCE OF RENAL FAILURE RENAL DIALYSIS Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Renal Failure - Renal Dialysis (c))											
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
						YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE	
22a. I certify that (1) (this hospital) attended the deceased from 22 Apr 1986 to 22 Apr 1986, that (1) (we) lost saw the deceased alive on 22 Apr 1986, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <i>Roy M. Krings</i>		22c. DEGREE				ATTENDING PHYSICIAN <input type="checkbox"/>		MEDICAL DIRECTOR <input type="checkbox"/>		STAFF PHYSICIAN <input type="checkbox"/>	
22d. PROFESSIONAL NAME (PRINTING) Roy M. Krings		22e. ADDRESS				MALCOLM GROW USAF MED CEN, ANDREWS AFB, MD				22c. DATE SIGNED 22 Apr 86	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS		23d. LOCATION CITY OR TOWN		COUNTY		STATE	
Burial		4/25/86		ARLINGTON NATIONAL		ARLINGTON				VIRGINIA	
24. FUNERAL DIRECTOR		2617 Pa Ave., S.E.		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
ALEXANDER S. POPE		ADDRESS 1617 Pa. Ave. S.E. D.B.		APR 28 1986		<i>Jane Swanson-Pandell</i>					

650910-1



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

2333

1 -
FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR	
LAFLORA			J.	OVERSTREET		4	8	1986	8:35 AM		
3. SEX		4. RACE	5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		
FEMALE		BLACIL	MONTH	DAY	YEAR	73	YRS			IF UNDER 24 HRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			
MISS.		U.S.A.						PRINCE GEORGE'S			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY			
CLINTON		SOUTHERN MARYLAND HOSPITAL			DOMESTIC			HOSPITAL			
13. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)						13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE		
13a. STATE		13b. COUNTY		13c. CITY OR TOWN					1892 BAY ST. S.E. 20746		
D.C.				WESLEY, D.C.							
14. FATHER'S NAME			FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME			FIRST	MIDDLE	LAST
ALLEN					MC DANIEL	FANNIE					BOWLES
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES OR NO OR UNKNOWN)			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)			17. INFORMANT			ADDRESS		
NO			230208644			MARGARET E. MITCHELL			1892 BAY ST. S.E. WASHINGTON, D.C.		
18. CAUSE OF DEATH (ENTER ONLY ONE CAUSE PER LINE FOR 1a), (b), AND (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIAC ARREST											
DUE TO, OR AS A CONSEQUENCE OF (b) CORONARY ARTERY DISEASE											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.											
DUE TO, OR AS A CONSEQUENCE OF (c) INTESTINAL OBSTRUCTION											
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 50 min											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART Ia HYPERTENSION											
21a. DATE OF OPERATION			21b. CONDITION FOR WHICH OPERATION WAS PERFORMED			21c. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
4/8/86			INTESTINAL OBSTRUCTION			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART II)					
21d. INJURY OCCURRED <input type="checkbox"/> WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN	COUNTY	STATE
22a. I certify that (I) (this hospital) attended the deceased from APRIL 7, 1986 , to APRIL 8, 1986 , that (I) (we) last saw the deceased alive on APRIL 8, 1986 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) did not view the body after death.											
22b. SIGNATURE			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED		
Benjamin H. Fidder, MD									4/8/86		
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS			22f. ADDRESS			22g. ADDRESS		
BENJAMIN H. FIDDER, MD			7501 SURRETT RD # 306, CLINTON, MD 20746			7501 SURRETT RD # 306, CLINTON, MD 20746			7501 SURRETT RD # 306, CLINTON, MD 20746		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN		
BURIAL			APR. 14, 1986			COLEMAN CEMETERY			ALEXANDRIA		
24. FUNERAL DIRECTOR NAME			ADDRESS			25e. DATE RECEIVED BY REGISTRAR			25f. SIGNATURE		
Greene Funeral Home Inc			814 Franklin St, Alex VA.			APR 14 1986					

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BP
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it may be forwarded to the Bureau of Vital Statistics for use in the Bureau's transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified by the hospital or attending physician.

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0-04286

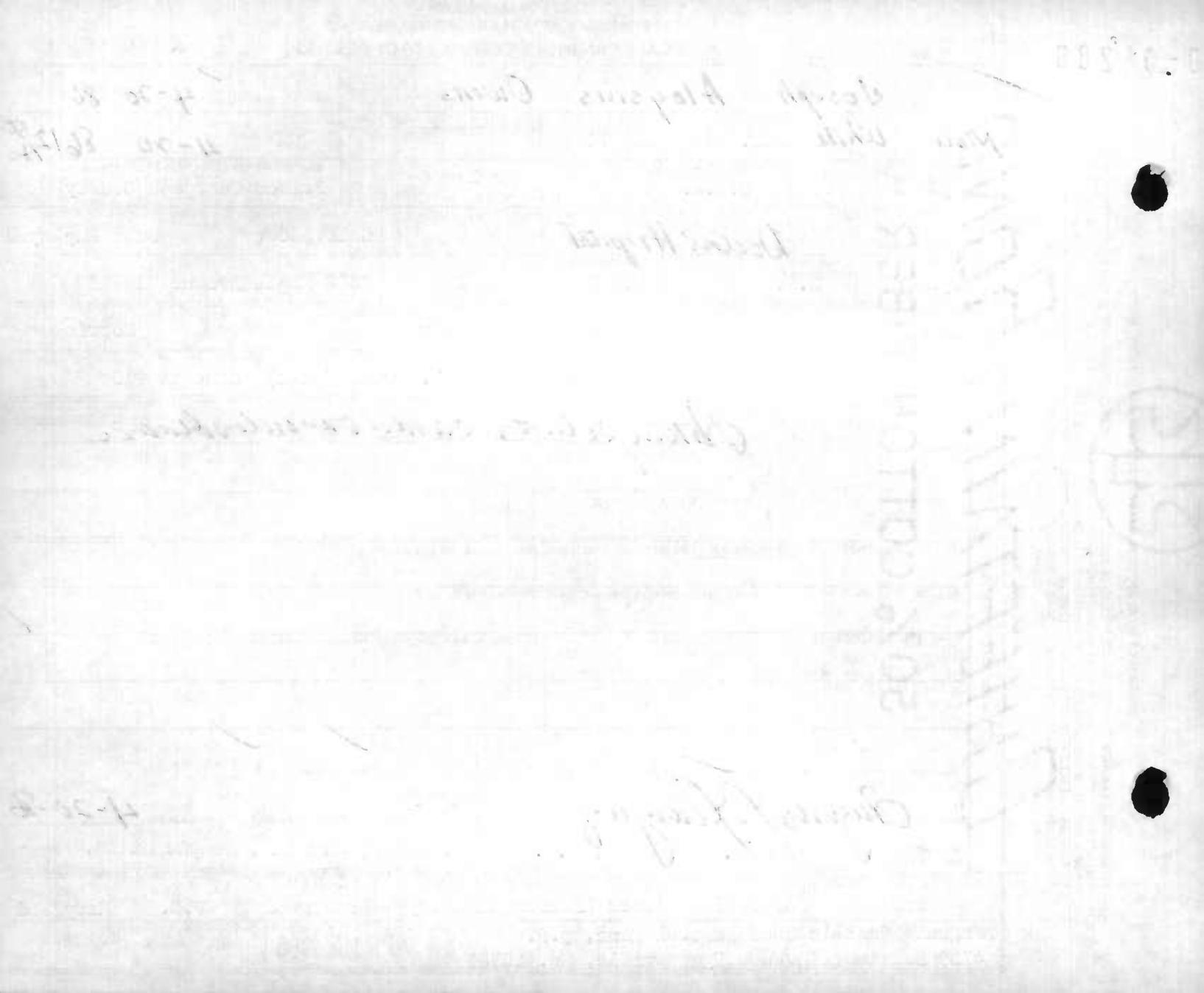
FOR
1 - STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

2334

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. RETAIN PAGE 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM, PM, 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT; PAGES 1 AND 2 SHOULD BE FILLED WITHIN 72 HOURS AFTER DEATH WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

1. DECEASED NAME (TYPE OR PRINT)		FIRST <i>Joseph</i>	MIDDLE <i>Aloysius</i>	LAST <i>Owens</i>	2a DATE KNOWN OF ESTI- DEATH MATED <input checked="" type="checkbox"/> 4-20 1986	MONTH M	DAY 1986	YEAR 1986	2b HOUR 12PM	
3. SEX <i>Male</i>	4. RACE <i>White</i>	5. DATE OF BIRTH MONTH DAY YEAR <i>Oct. 14, 1911</i>	6. AGE (IN YEARS LAST BIRTHDAY) YRS. <i>74</i>	7. IF UNDER 1 YR. MONTHS DAYS <input type="checkbox"/>	8. IF UNDER 24 HRS. HOURS MIN <input type="checkbox"/>	9c. DATE PRONOUNCED DEAD <i>4-20 1986</i>	MONTH 1986	DAY 12PM	2d HOUR 12PM	
7b. BIRTHPLACE STATE OR COUNTRY <i>Maryland</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Prince George's County</i>			MD.	
10. CITY OR TOWN OF DEATH <i>Lanham</i>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION <i>Doctors' Hospital</i>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Contractor</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Self Employed</i>		
13a. STATE <i>Maryland</i>	13b. COUNTY <i>P.G.</i>	13c. CITY OR TOWN <i>Bowie</i>	13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	13e. STREET ADDRESS <i>8808 Maple Avenue 20715</i>						
14. FATHER'S NAME <i>Daniel</i>		MIDDLE <i></i>	LAST <i>Owens</i>	15. MOTHER'S MAIDEN NAME <i>Mary</i>		MIDDLE <i></i>	LAST <i>Norris</i>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <i>NO</i>		16b. SOCIAL SECURITY NO. <i>218-09-5131A</i>		17. INFORMANT <i>Anna L. Owens (Wife)</i>		ADDRESS <i>Same as #13</i>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: <i>Arterio-venous vascular disease</i> IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY	STATE	
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> and in my opinion										
ACTUAL SIGNATURE <i>Augusto P. Rodriguez</i>		TIME SPECIFIED M.D. <i>Deputy</i>		MEDICAL EXAMINER						DATE SIGNED <i>4-20-86</i>
EXAMINER'S NAME (TYPE OR PRINT) <i>Augusto P. Rodriguez, M.D.</i>		ADDRESS <i>5009 Rayburn Ct, Temple Hills, MD</i>								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>4/23/86</i>		23c. NAME OF CEMETERY OR CREMATORIUM <i>Fort Lincoln Cemetery</i>		23d. LOCATION CITY OR TOWN <i>Brentwood</i>		COUNTY <i>P.G.</i>	STATE <i>Maryland</i>	
24. FUNERAL DIRECTOR NAME <i>Francis Gasch's Sons Funeral Home, p.A.</i>		ADDRESS <i>4739 Baltimore Avenue Hyattsville, Md. 20781</i>		25a. DATE REC'D. BY REGISTRAR <i>APR 22 1986</i>		25b. REGISTRAR'S SIGNATURE <i>Jean Davidson-Hanover</i>				



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death.

Reissued by Dr. Med. Examiner

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper. Page 3 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or if item 18 shows any injury, or other traumatic event, the medical examiner will be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH													
8 R.R. NO. 1 2 3 3 5													
1 - STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT)			FIRST JOHN		MIDDLE C.		LAST PAPAVASILIOU		2d. DATE OF DEATH MONTH 04 DAY 24 YEAR 86		
3. SEX		4. RACE			5. DATE OF BIRTH MONTH March DAY 25 YEAR 1902			6. AGE (IN YEARS LAST BIRTHDAY) 84 YRS			2b. HOUR 5 19PM M		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGE'S COUNTY MD.					
10. CITY OR TOWN OF DEATH CHEVERLY		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) PRINCE GEORGE'S GENERAL HOSPITAL						12a. USUAL OCCUPATION Self-employed			12b. KIND OF BUSINESS OR INDUSTRY Shoe Maker		
13a. STATE Maryland		13b. COUNTY Charles		13c. CITY OR TOWN Waldorf		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 6320 Josephine Road 20601					
14. FATHER'S NAME FIRST Christos		MIDDLE		LAST Papavasiliou		15. MOTHER'S MAIDEN NAME First Sofia		Middle		Last Makasiky			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO (IF YES, GIVE WAR OR DATES) - - -		16c. INFORMANT 092-16-4890		17. ADDRESS Margaret Papavasiliou Waldorf, MD 20601							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIOPULMONARY ARREST</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>CARDIOGENIC SHOCK</u> . DUE TO, OR AS A CONSEQUENCE OF (c) <u>ACUTE GI BLEED</u> .												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 MINUTES	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>DIABETES, CARDIAC DISEASE, COPD, ALCOHOL</u>													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, INDICATE MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 21b PART 2) 1986								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT HOME <input type="checkbox"/> AT PLAY <input type="checkbox"/>		21e. PLACE OF INJURY (EX. HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN					
22a. I certify that (I) (this hospital) attended the deceased from above, (II) (we) did not see the deceased alive on <u>4-24-86</u> , and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (III) (we) did not view the body after death.													
22b. SIGNATURE <u>Samuel W. Alleyne</u>					DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 4-25-86		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Samuel W. Alleyne, M. D.					22e. ADDRESS 914 Larch Ave. Takoma Park, Maryland								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE APR 29, 1986			23c. NAME OF CEMETERY OR CREMATORIAL George Washington Cem.			23d. LOCATION CITY OR TOWN Adelphi, Pr. George's, MD					
24. FUNERAL DIRECTOR NAME <u>Keith Blakes</u> Beall Funeral Home		ADDRESS 16000 Annapolis Road Bowie, MD 20715-3043			25a. DATE REC'D. BY REGISTRAR MAY 5 1986			25b. REGISTRAR'S SIGNATURE <u>John J. Murphy</u>					

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1- FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8612336
REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR		
ADDIE F PARK						APRIL 22, 1986	86	12336	7:45 AM			
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS		
Female		Caucasian		MONTH	DAY	YEAR	104	MONTHS	DAYS	HOURS	MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH		MD.				
Virginia		USA				Prince George's Co.						
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY				
Laurel		Greater Laurel Nursing Home				housewife		home				
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE				
Maryland		Howard		Columbia				6553 Carlinda Ave 21046				
14. FATHER'S NAME		FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME							
John				Hall	Lucretia							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS						
no		153 36 1444		Ever Park same as above								
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) RESPIRATORY ARREST APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH												
DUE TO, OR AS A CONSEQUENCE OF (b) PNEUMONIA												
DUE TO, OR AS A CONSEQUENCE OF (c) GENERALIZED ATHEROSCLEROSIS												
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)												
19a. MEDICAL CERTIFICATION		19b. DATE OF OPERATION		19c. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE		
22a. I certify that (I) (this hospital) attended the deceased from the deceased alive on 4/17/86, and that in (my) our opinion death occurred on the date and hour and from the causes stated above. (I) we did not view the body after death.												
22b. SIGNATURE				DEGREE		ATTENDING MEDICAL PHYSICIAN <input checked="" type="checkbox"/> STAFF DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED				
								4-22-86				
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS										
Gregory Compton, MD		14201 Laurel Park Dr. Suite 221, Laurel										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIUM		23d. LOCATION CITY OR TOWN		23e. COUNTY		23f. STATE		
burial		4-24-1986		Union Cemetery		Burtonsville		Md		State		
24. FUNERAL DIRECTOR NAME Donaldson Funeral Home P.A.		ADDRESS Laurel, Maryland		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE						
				APR 28 1986		Juli Donaldson						

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, Pages 1 and 2 should be detached for use as the burial/transit permit. Then please return to the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must

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220th VAP Battalion

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 12331

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONE. THIS FORM PM 3, RETAIN PAGE 5 FOR YOUR FILES.

TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. AGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

1- FOR STATE REGISTRAR		LAST						2a. DATE KNOWN <input type="checkbox"/> MONTH DAY YEAR OF ESTI- DEATH MATED <input type="checkbox"/> 4-15 1986 M			
4. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE				2b. HOUR			
<i>Bernard Lutters Parker</i>								4-15 1986 640 M			
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YR. MONTHS	IF UNDER 24 HRS. DAYS	HOURS	MIN.
<i>Male</i>		<i>White</i>		<i>1-2-30</i>		<i>56 yrs.</i>					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Prince Georges.</i>					
10. CITY OR TOWN OF DEATH <i>Lanham</i>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH A CITY, GIVE STREET ADDRESS) <i>7320 Oliver Street</i>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Service Technician H.S. Gov't.</i>		12b. KIND OF BUSINESS OR INDUSTRY					
13a. STATE <i>Md.</i>		13b. COUNTY <i>P.G.</i>		13c. CITY OR TOWN <i>Lanham</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <i>7320 Oliver St. 20706</i>			
14. FATHER'S NAME FIRST <i>Raymond</i>		MIDDLE <i></i>		LAST <i>Parker</i>		15. MOTHER'S MAIDEN NAME FIRST <i>Florance</i>		LAST <i>Prosise</i>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <i>Yes</i>		(IF YES, GIVE WAR OR DATES) <i>8/2/48 to</i>		16b. SOCIAL SECURITY NO. <i>578-34-0143</i>		17. INFORMANT <i>Joan Parker</i>		ADDRESS <i>7320 Oliver St. Lanham, Md. 20706</i>			
<p>18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)). PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE <i>Arteriosclerotic cardiovascular disease</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. <i></i> (b) <i></i> DUE TO, OR AS A CONSEQUENCE OF (c) <i></i></p> <p>PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).</p>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE	
<p>22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input type="checkbox"/>, and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/>, Accident <input type="checkbox"/>, Suicide <input type="checkbox"/>, Homicide <input type="checkbox"/>, Undetermined manner <input type="checkbox"/>.</p> <p>ACTUAL SIGNATURE <i>Augusto P. Rodriguez MD</i> M.D. Deputy MEDICAL EXAMINER</p> <p>EXAMINER'S NAME (TYPE OR PRINT) <i>Augusto P. Rodriguez MD</i></p> <p>ADDRESS <i>3029 Keyhen Ct., Langley, Md. 20748</i></p> <p>DATE SIGNED <i>4-15-86</i></p>											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE <i>4/19/86</i>		23c. NAME OF CEMETERY OR CREMATORIAL <i>Gate of Heaven Cemetery</i>		23d. LOCATION CITY OR TOWN <i>Silver Spring</i>		COUNTY <i>Montgomery</i>		STATE <i>Md.</i>	
24. FUNERAL DIRECTOR NAME		24a. DATE REC'D. BY REGISTRAR		25c. REGISTRAR'S SIGNATURE							
<i>Rendon/Hale Lanham Funeral Home 9013 Annapolis Rd. Lanham, Md. 20706</i>		<i>APR 18 1986</i>		<i>Yvonne Davis</i>							

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TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be received within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

10. FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 and 2 should be detached for view at the Burial Permit Office prior to burial, cremation, or removal with the State Dept. of Health and Mental Hygiene or to other facility. If item 21 is marked "No" or if there was any injury, or other traumatic event, the medical certificate must be completed.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8	6	2	3	3	8
												REG. NO.					
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	20. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR					
Mattie M. Paull						4-5-1986						3:37 A.M.					
3. SEX			4. RACE		5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS				
Female			White		Sept. 18 1917			68			MONTHS		DAYS				
7a. BIRTHPLACE (COUNTRY) Virginia			7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's MD.									
10. CITY OR TOWN OF DEATH Clinton			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (DO NOT ENTER FACILITY NAME, GIVE STREET ADDRESS) Southern Maryland Hospital Center		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Durodr Engrav.			12b. KIND OF BUSINESS OR INDUSTRY Fed. Gov't.									
13a. STATE Maryland			13b. COUNTY Prince George		13c. CITY OR TOWN Forestville			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE 3510 Pine Vale Avenue 20747						
14. FATHER'S NAME LaVan			MIDDLE	LAST	15. MOTHER'S MAIDEN NAME Pheebe			16. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 weeks			LAST Miller						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. 579-12-3113		17. INFORMANT Linda Hogge			3510 Pine Vale Avenue Forestville, Maryland									
18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b), and ic PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Pneumostatic heart & failure</i> { DUE TO, OR AS A CONSEQUENCE OF (b) <i>Atrial Selectic heart disease 4 yrs</i> { DUE TO, OR AS A CONSEQUENCE OF (c)																	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a																	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART 1 OR PART 2) <i>fell</i>											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT HOME <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) <i>At home</i>			21f. LOCATION STREET <i>85</i> CITY OR TOWN <i>Forest</i> COUNTY <i>Prince George's</i> STATE <i>MD</i>											
22a. I certify that (i) this hospital obtained the deceased from now the deceased alive on <i>April 8, 1986</i> to <i>April 8, 1986</i> (ii) (we) last saw the deceased alive on <i>April 8, 1986</i> to <i>April 8, 1986</i> (iii) (we) did (did not) saw the body after death																	
22b. SIGNATURE <i>Herbert Wizotsky</i>			22c. DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22d. DATE SIGNED x 4-5-86											
22e. PHYSICIAN'S NAME (TYPE OR PRINT) <i>HERBERT WIZOTSKY MD</i>			22f. ADDRESS 6188 Oxon Hill Rd. Oxon Hill, Md.														
23a. BURIAL, CREMATION, REMOVAL SPECIFY <i>Burial</i>			23b. DATE 4/8/86		23c. NAME OF CEMETERY OR CREMATORIUM Ft. Lincoln Cemetery			23d. LOCATION CITY OR TOWN <i>Brentwood</i> COUNTY <i>P.G.</i> STATE <i>Maryland</i>									
24. FUNERAL DIRECTOR NAME <i>George P. Kalas Funeral Home</i>			25a. DATE REC'D. BY REGISTRAR APR 9 - 1986			25b. REGISTRAR'S SIGNATURE <i>Susan Davidson-Rondell</i>											
6160 Oxon Hill Rd. Oxon Hill, Md.																	

	NAME	ADDRESS	TELEGRAM	TELEGRAM	TELEGRAM
38	STAFF ST. 18 Sept.	STAFF	STAFF	STAFF	STAFF
	BRITISH EMBASSY	X	1.2.1	1.2.1	1.2.1
RESULTS	CONFIDENTIAL INFORMATION CENTER				CONFIDENTIAL
	370 BIRKBECK AVENUE	X	CONFIDENTIAL	CONFIDENTIAL	CONFIDENTIAL
RESULTS	BRITISH EMBASSY		CONFIDENTIAL	CONFIDENTIAL	CONFIDENTIAL
	370 BIRKBECK AVENUE	X	CONFIDENTIAL	CONFIDENTIAL	CONFIDENTIAL
RESULTS	BRITISH EMBASSY		CONFIDENTIAL	CONFIDENTIAL	CONFIDENTIAL
	370 BIRKBECK AVENUE	X	CONFIDENTIAL	CONFIDENTIAL	CONFIDENTIAL

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please affix your signature to pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examination must be completed before the certificate is issued.

MEDICAL CERTIFICATION

1 - FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 1 2 3 3 9
REG. NO.

1. DECEASED NAME (TYPE OR PRINT)					FIRST <i>Eloise Baby Girl</i>	MIDDLE <i>Vantrace</i>	LAST <i>Austin</i>	2a. DATE OF DEATH MONTH DAY YEAR	2b. HOUR 7.55 A						
3. SEX <i>Female</i>		4. RACE <i>Black</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>4 27 86</i>			6. AGE (IN YEARS LAST BIRTHDAY) 0 YRS. MONTHS 0 0		IF UNDER 1 YEAR MONTHS 0 0		IF UNDER 24 HRS. HOURS 2 20 MIN.				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>MD Maryland</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH <i>PRINCE GEORGES</i>		MD.						
10. CITY OR TOWN OF DEATH <i>Cheverly</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>PRINCE GEORGES GEN HOSPITAL</i>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>N/A Infant</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>None</i>									
13a. STATE <i>Maryland</i>		13b. COUNTY <i>Prince Georges</i>		13c. CITY OR TOWN <i>Landover</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <i>3145 75th Avenue, Apt. 4 (20785)</i>							
14. FATHER'S NAME FIRST <i>Vance</i>		MIDDLE <i>Danny</i>		LAST <i>Payne</i>		15. MOTHER'S MAIDEN NAME FIRST <i>PATRICIA</i>		MIDDLE <i>Patricia Ann Grier</i>		LAST <i>AUSTIN</i>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>NA</i>		16b. SOCIAL SECURITY NO. <i>NA</i>		17 INFORMANT <i>3145 75th Avenue, Apt. 4</i>		ADDRESS <i>Patricia A. Austin (mother) Landover, Md.</i>									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>PRE VIABLE</i> DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c))												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)															
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <i>19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)											
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE					
22a. I certify that (I) (this hospital) attended the deceased from <i>2 AM 4/27 1986</i> , to <i>7:55 AM 4/27 1986</i> . that (I) (we) last saw the deceased alive on <i>baby death</i> , 19 <i>19</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (we) (did) (did not) view the body after death.															
22b. SIGNATURE <i>L. Jay Gopalan</i>		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/>		MEDICAL DIRECTOR <input type="checkbox"/>		STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <i>April 30, 1986</i>					
22d. PHYSICIAN NAME (TYPE OR PRINT) <i>L. J. GOPALAKRISHNAN</i>		22e. ADDRESS <i>NURSERY PO-CH Cheverly MD</i>													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>05/01/86</i>		23c. NAME OF CEMETERY OR CREMATORIAL <i>Washington National</i>		23d. LOCATION CITY OR TOWN <i>Suitland P.G.C. Maryland</i>		23e. COUNTY		STATE					
24. FUNERAL DIRECTOR NAME <i>Latney's Funeral Home</i>		25a. DATE REC'D. BY REGISTRAR <i>MAY 12 1986</i>		25b. REGISTRAR'S SIGNATURE <i>Johndavidson-Gopalan</i>											
3831 Georgia Avenue, NW; Washington, DC 20011															

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours by the attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove with the State Dept. of Health and Mental Hygiene prior to burial, cremation or other disposition.

IMPORTANT: If item 21 is marked or Item 18 shows any injury, or after the medical examiner must be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												
1. DECEASED NAME (TYPE OR PRINT)				FIRST Irma	MIDDLE C.	LAST Payne	2a. DATE OF DEATH	MONTH 4-23-86	DAY	YEAR	2b. HOUR 6:15a	
3. SEX Female		4 RACE White		5 DATE OF BIRTH MONTH DAY YEAR February 16, 1891			6 AGE (IN YEARS LAST BIRTHDAY) 95		IF UNDER 1 YEAR YRS.		IF UNDER 24 HRS MONTHS DAYS HOURS MIN	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA			8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Prince Georges			MD.		
10. CITY OR TOWN OF DEATH Laurel		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 6911 Redmiles Road			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) nurse			12b. KIND OF BUSINESS OR INDUSTRY private duty				
13a. STATE Maryland		13b. COUNTY Prince Georges		13c. CITY OR TOWN Laurel		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 6911 Redmiles Road 20707				
14. FATHER'S NAME FIRST William		MIDDLE George	LAST Hall	15. MOTHER'S MAIDEN NAME Lucy			16. ADDRESS Stevens					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? NO		16b. SOCIAL SECURITY NO. 579 24 1467			17. INFORMANT Norma Hall same as above							
18. CAUSE OF DEATH (Enter only one cause per line for 1(a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Heart failure</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>coronary artery disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u></u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>weeks</u> <u>years.</u>												
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN	COUNTY	STATE		
22a. I certify that (I) this hospital attended the deceased from <u>October 83</u> to <u>April 23, 1986</u> , the (I/we) last saw the deceased alive on <u>April 21, 1986</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I/we) did not view the body after death.												
22b. SIGNATURE <u>Bruce W. Gattis</u>		22c. DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/>			MEDICAL DIRECTOR <input type="checkbox"/>	STAFF PHYSICIAN <input type="checkbox"/>	22d. DATE SIGNED <u>4/23/86</u>		
22e. PHYSICIAN'S NAME, TITLE OR POSITION <u>BRUCE W. GATTIS</u>		22f. ADDRESS <u>#200, 14333 LAUREL-BOWIE RD.</u>										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE April 25, 1986		23c. NAME OF CEMETERY OR CREMATORIAL Columbia Gardens			23d. LOCATION CITY OR TOWN Arlington, Va.					
24. FUNERAL DIRECTOR NAME Donaldson Funeral Home, Laurel, Md.		ADDRESS			25a. DATE REC'D. BY REGISTRAR APR 29 1986			25b. REGISTRAR'S SIGNATURE Julia Davidson-Jordan				
DHMH-16 25M (VRA 15, 4) 1/79												

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out of the water

APR 28 1988 8:58 AM

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be detached for use as the burial/transit permit. Then please remove carbon paper. Page 1 and 2 should be used within 72 hours after death, with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 86	1 2 3 4 1
1. RELEASED NAME <small>(TYPE OR PRINT)</small>		FIRST	MIDDLE	LAST	2a. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR	
ANITA			MANCINI	PEARY	April 14, 1986					1:53 A.M.	
1. SEX		RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)					
Female		Caucasian		October 06, 1916		69					
6		7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>					
DeJaware		U.S.A.									
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION		12b. KIND OF BUSINESS OR INDUSTRY					
Lanham		Magnolia Gardens Nursing Home		Clerk		Peoples Drug					
13a. STATE		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS / ZIP CODE					
Maryland		Anne Arundel Annapolis		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		130 Hearn Road 21401					
14. FATHER'S NAME		FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME		FIRST	MIDDLE	LAST	APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
Guido				Mancini	Angelina				Greillo		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS					
No		222-07-0853		Victor G. Peary (Son) Seabrook, Md. 20706		9406 Underwood Street					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)											
DUE TO, OR AS A CONSEQUENCE OF (b) Large cell carcinoma Right lung with metastasis to brain DUE TO, OR AS A CONSEQUENCE OF (c) November 1985 to April 1986											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)		YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>Feb 25, 1986</u> to <u>April 14, 1986</u> , that (I) (we) last saw the deceased alive on <u>April 1, 1986</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not see the body before death.											
22b. SIGNATURE		22c. DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22d. ADDRESS		22e. DATE SIGNED 4/14/86			
R. Lee-Llacer		MD				890906 Branch Ave Clinton Md					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL		23d. LOCATION					
Burial		04/16/86		Mt. Olivet Cemetery		Washington, D.C.					
24. FUNERAL DIRECTOR		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE							
Francis Gasch's Sons Funeral Home, P.A.		APR 16 1986		John L. Llacer							
4739 Baltimore Avenue Hyattsville, Md. 20781											

1650-10

2000 ft. (41) West (W. 2nd, year 1)
soil derived from sand
gravel, 2000 ft. below surface
soil derived from sand
gravel, 2000 ft. below surface

Misnomer due to lack of soil

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

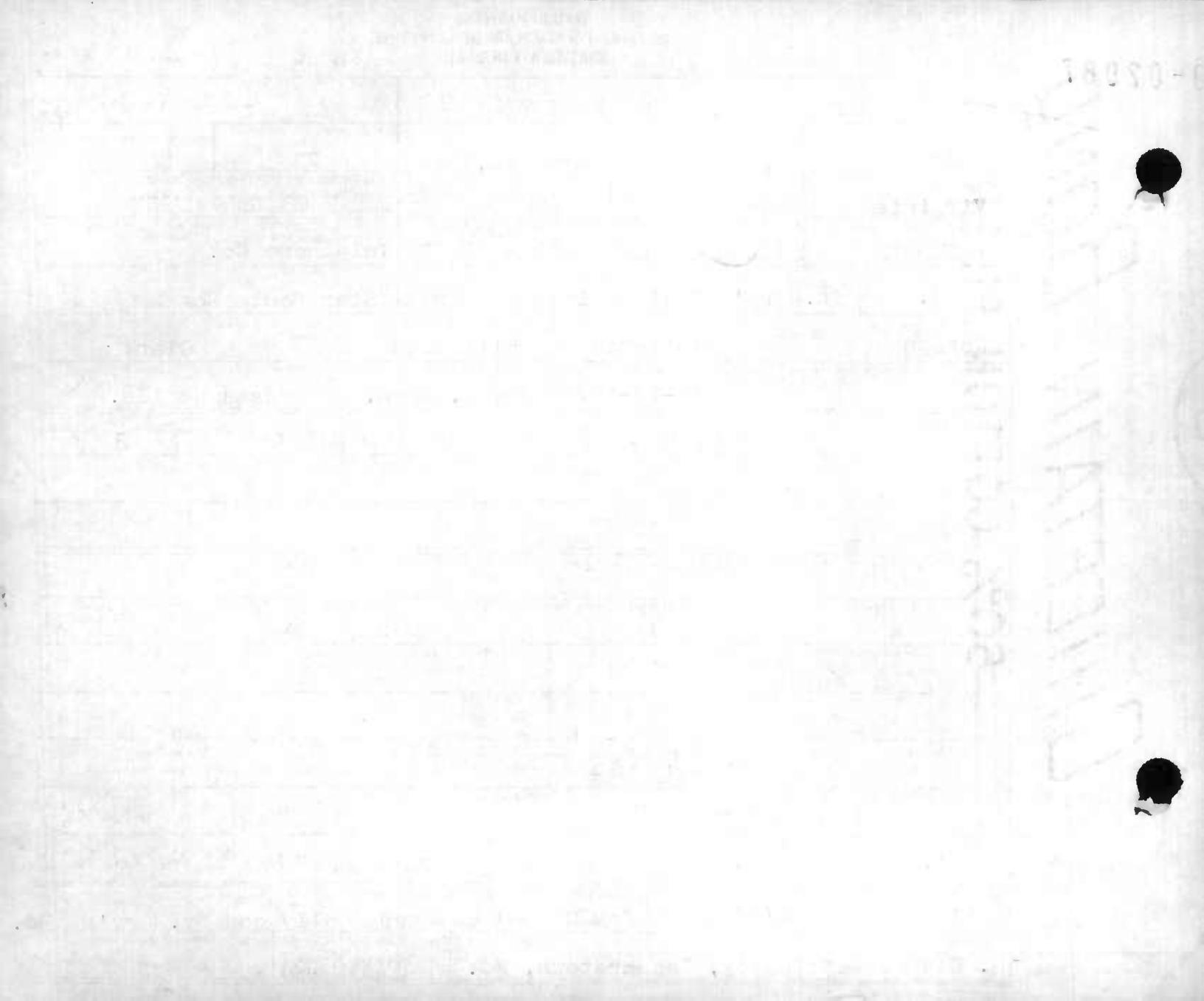
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial permit. Then please remove carbon copies, pages 1 and 2, which will be filed with the death certificate at the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury or other traumatic event, the medical examiner must be informed.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 12342			
1 - STATE REGISTRAR		2a. DATE OF DEATH 4-4-86								2b. HOUR 6:45 P.M.			
I. DECEASED NAME (TYPE OR PRINT)		FIRST JOHN	MIDDLE B.	LAST PINGLETON									
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH March 12, 1913			6. AGE (IN YEARS LAST BIRTHDAY) 73 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS		8. IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE COUNTRY Virginia		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGE'S COUNTY MD.						
10. CITY OR TOWN OF DEATH Clinton		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SOUTHERN MARYLAND HOSPITAL CENTER								12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Telephone Co.			
13a. STATE Md.		13b. COUNTY St. Mary's		13c. CITY OR TOWN California			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE Star Route Box 2 20679				
FATHER'S NAME First: Joseph		MIDDLE	Last: Pingleton	15. MOTHER'S MAIDEN NAME First: Elizabeth			MIDDLE		LAST Clark				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (S. NO. OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 212-14-5476		17. INFORMANT Mary J. Owen,			ADDRESS Same as 13e.						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Small cell lung cancer with liver metastasis										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 wks.			
DUE TO, OR AS A CONSEQUENCE OF (b) _____													
DUE TO, OR AS A CONSEQUENCE OF (c) _____													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED								20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE			
22a. I certify that (I) (this hospital) attended the deceased from March 25, 1986, to April 4, 1986, that (I) (we) last saw the deceased alive on March 4, 1986, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we did not see the body after death, check here.)													
22b. SIGNATURE <i>John Y. Young, M.D.</i>		22c. DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22d. DATE SIGNED 4-4-86							
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Tai-Yin Young, M.D.		22e. ADDRESS 8926 Woodyard Rd #201 Clinton, MD 20735											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 4/7/86		23c. NAME OF CEMETERY OR CREMATORIAL Joy Chapel Cemetery		23d. LOCATION CITY OR TOWN Hollywood St. Mary's Md.							
24. FUNERAL DIRECTOR NAME W. Clarke Mattingley, Leonardtown, Md.		ADDRESS		25a. DATE REC'D. BY REGISTRAR APR 09 1986		25b. REGISTRAR'S SIGNATURE Greta Davidson-Randall							
BP _____													

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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												
8 0 1 2 3 4 5 REG. NO.												
1 - FOR STATE REGISTRAR	1. DECEASED NAME			FIRST	MIDDLE	LAST	2a DATE OF DEATH	MONTH	DAY	YEAR	2b HOUR	
	Mildred			M		Poole	April	1,	1986	2:15 a.m.		
3. SEX	4. RACE			5. DATE OF BIRTH			6 AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR		IF UNDER 24 HRS		
Female	White			Sept. 21 1910			75	YEARS	MONTHS	DAYS	HOURS	MIN.
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b CITIZEN OF WHAT COUNTRY?			8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH					
West Virginia	USA						Prince George's MD.					
10 CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b KIND OF BUSINESS OR INDUSTRY					
Riverdale, Md.	Leland Memorial			Secretary			Retail Clerk's					
13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)												
13a STATE	13b COUNTY	13c CITY OR TOWN	13d INSIDE CITY LIMITS?			13e STREET ADDRESS / ZIP CODE						
Maryland	Pr. George's	W. Hyattsville	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			2729 Nicholson St. 20782						
14 FATHER'S NAME	FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME			FIRST	MIDDLE	LAST			
	William	Percie	Poole	Lula			May		Butts			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	16b SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS					
No	577-22-2647			Helen Poole RFD Hedgesville, WV 25427								
18 CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c)												
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MASSIVE STROKE												
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH HOURS												
DUE TO, OR AS A CONSEQUENCE OF (b) HYPERTENSION												
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c)												
DUE TO, OR AS A CONSEQUENCE OF												
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE												
MEDICAL CERTIFICATION		19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY?	20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
								YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)								
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET		CITY OR TOWN		COUNTY		STATE		
22a I certify that (I) (this hospital) attended the deceased from 3-31-1986 to 4-1-1986, that (I) (we) last saw the deceased alive on 3-31-1986 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.												
22b SIGNATURE Mohammed A. Mannan, M.D., DEGREE												
22d PHYSICIAN'S NAME (TYPE OR PRINT)		22e ADDRESS		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> MEDICAL STAFF PHYSICIAN <input type="checkbox"/>		22c DATE SIGNED April 1, 1986						
Mohammed A. Mannan, M.D.		3715 Rhode Island Ave., Mt. Rainier, Md.				20712						
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b DATE 4/5/86		23c NAME OF CEMETERY OR CREMATORIAL Bethel Cemetery		23d LOCATION CITY OR TOWN RFD Hedgesville		COUNTY		STATE Berkeley WV		
24 FUNERAL DIRECTOR Charles M. Brown Brown Funeral Home		327 W. King St POBOX 821, Martinsburg, WV		ADDRESS		25a. DATE REC'D. BY REGISTRAR APR 10 1986		25b. REGISTRAR'S SIGNATURE Julia Davidson-Pendell				
DHMH - 16 60M 7/84 (VRA 15, 4)												

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be signed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician, it must be completely filled in by the funeral director. Page 3 should be detached for use as the burial permit. Then please remove carbon copy of page 2. Item 2 should be filed within 72 hours after death.

IMPORTANT: If item 21 is marked it shows any injury, or other traumatic event, the medical examiner should be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO. 12344	
1 - FOR STATE REGISTRAR			1. DECEASED NAME (TYPE OR PRINT)			FIRST EDNA MIDDLE Mae LAST QUILLIN			2a. DATE OF DEATH 04-03-86			2b. HOUR 2 :00PM	
3. SEX Female			4. RACE White			5. DATE OF BIRTH MONTH May DAY 4 YEAR 1899			6. AGE (IN YEARS LAST BIRTHDAY) 86			IF UNDER 1 YEAR MONTHS 0 DAYS HOURS 0 MIN. 0	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) West Virginia			7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGE'S COUNTY MD.				
10. CITY OR TOWN OF DEATH CHEVERLY			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION PRINCE GEORGE'S GENERAL HOSPITAL			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife			12b. KIND OF BUSINESS OR INDUSTRY Home				
13. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland 13b. COUNTY Prince George 13c. CITY OR TOWN Hillside			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE 915 Drum Avenue 20743							
14. FATHER'S NAME FIRST UNKNOWN MIDDLE LAST			15. MOTHER'S MAIDEN NAME FIRST UNKNOWN MIDDLE LAST Haines										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES OR NO UNKNOWN) No			16b. SOCIAL SECURITY NO. 217 05 7657			17. INFORMANT Bernie F Quillin			ADDRESS Owens Md 3530 Halls Creek Lane				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory arrest APPROXIMATE INTERVAL Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF GI bleeding DUE TO, OR AS A CONSEQUENCE OF (c) Cancer Colon, fibrillation. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I CONGESTIVE HEART FAILURE												BETWEEN ONSET AND DEATH Several days.	
19a. MEDICAL CERTIFICATION DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART II)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from 3/30/86 to 4/3/86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE <i>S. Quillin</i>			22c. DEGREE MD			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22d. DATE SIGNED 4/4/86				
22e. PHYSICIAN'S NAME (TYPE OR PRINT) <i>S. Quillin</i>			22f. ADDRESS P.G. Hospital CD Dept Cheverly, Md						20785				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 7 April 186			23c. NAME OF CEMETERY OR CREMATORIAL Cedar Hill Cemetery			23d. LOCATION Suitland CITY/TOWN Maryland COUNTY				
24. FUNERAL DIRECTOR NAME Robert E Wilhelm Funeral Home Suitland Maryland			25a. DATE REC'D. BY REGISTRAR APR 8 1986			25b. REGISTRAR'S SIGNATURE <i>Julia Davidson Pendleton</i>							

CBGEO-1

10

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be submitted within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper pages 1 & 2 and file within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												
8 REC. NO. 1 2 3 4 5												
1 - FOR STATE REGISTRAR	1. DECEASED NAME (TYPE OR PRINT)			FIRST MINNIE			LAST RANDOLPH			2d DATE OF DEATH 04-02-86		
										MONTH DAY YEAR		
										2b HOUR 10 :05AM		
										M		
2 - DECEASED FEMALE	3. SEX FEMALE			4. RACE BLACK			5. DATE OF BIRTH MONTH 8 DAY 1 YEAR 1896			6. AGE 89 IN YEARS LAST BIRTHDAY		
										IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
										YRS.		
										PRINCETON		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGE'S COUNTY					
N.C.	U.S.A.									MD		
10. CITY OR TOWN OF DEATH CHEVERLY	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION PRINCE GEORGE'S GENERAL HOSPITAL						12a. USUAL OCCUPATION NONE			12b. KIND OF BUSINESS OR INDUSTRY		
										20785		
13a. STATE MARYLAND	13b. COUNTY LANDOVER			13c. CITY OR TOWN CO.			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE 1107 CAPITAL VIEW DR.		
14. FATHER'S NAME ABRAM JONES							15. MOTHER'S MAIDEN NAME AMANDA DAVIS					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES OR UNKNOWN) NO	16b. SOCIAL SECURITY NO. 239-12-0797			17. INFORMANT JAMES BARNES			ADDRESS 1107-CAPITAL VIEW DR.					
18. CAUSE OF DEATH PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	Brain Abcesses									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 weeks		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last	(b)											
(c)												
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)	Diabetes mellitus, multiple Cerebrovascular Accident											
MEDICAL CERTIFICATION	19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from 11/1, 1986, to 4/2, 1986, that (I) (we) last saw the deceased alive on 4/1, 1986, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we did) (did not) view the body after death.												
22b. SIGNATURE Dorothy Yablonsky	22c. DEGREE MD			22d. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22e. DATE SIGNED 4/2/86					
22e. PHYSICIAN'S NAME (TYPE OR PRINT) Dorothy Yablonsky	22f. ADDRESS 10300 Greenbelt Rd, Seabrook, Md.											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL	23b. DATE 4/8/86			23c. NAME OF CEMETERY OR CREMATORIAL FT. LINCOLN			23d. LOCATION MT. RAINER MD.					
24. FUNERAL DIRECTOR NAME HOFFMAN FUNERAL HOME 3605-14th ST N.W. WASHINGTON D.C. 20010	25a. DATE REC'D. BY REGISTRAR APR 10 1986			25b. REGISTRAR'S SIGNATURE Julie Davidson-Randall								
BP												
DHMH - 16 60M 7-84 (VRA 15, 4)												

10180-3

WYOMING STATE ARCHIVES

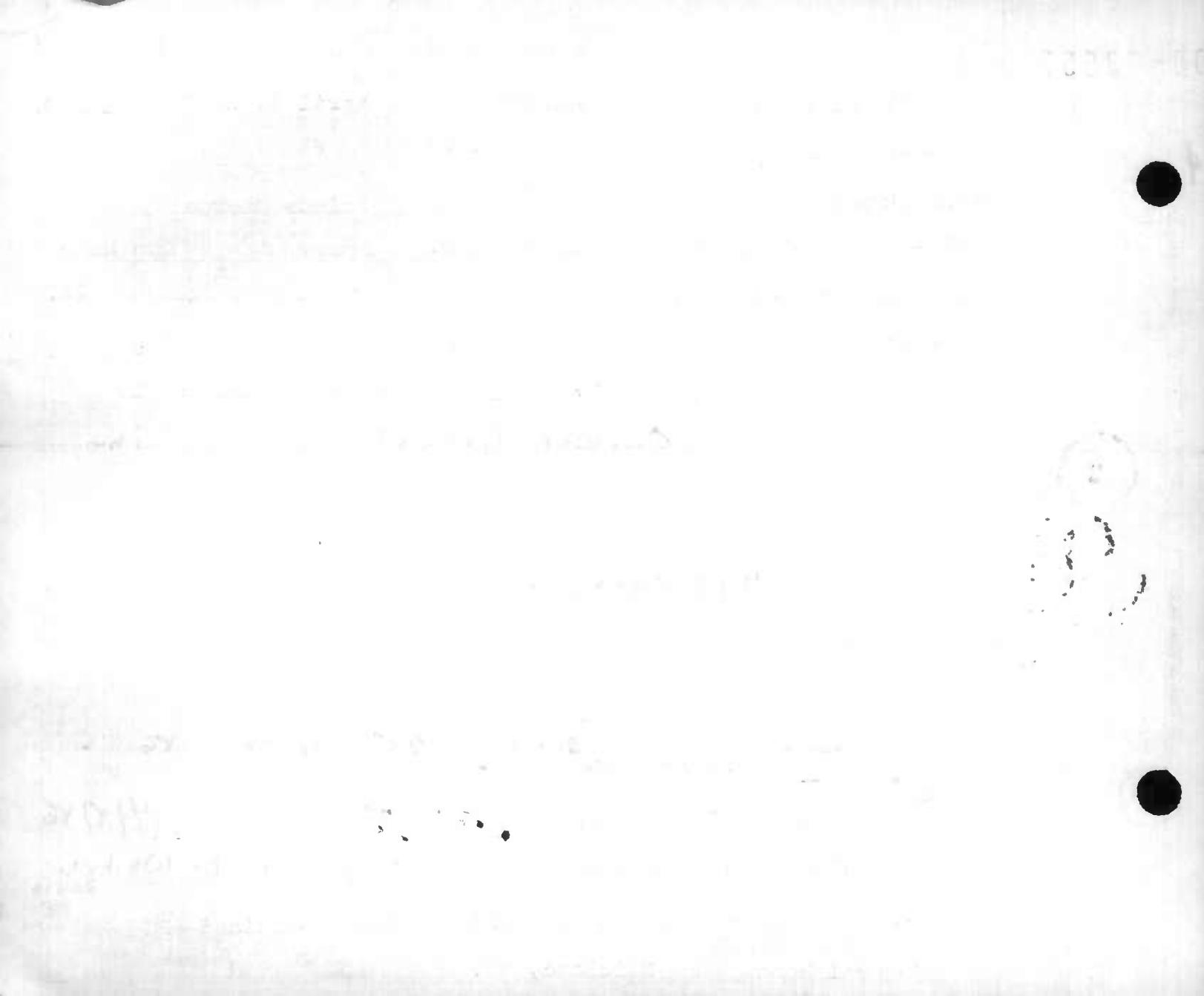


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return carbon copies, Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or other disposal.

IMPORTANT: If item 21 is marked or item 20 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO. 8512346		
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR		
Wilhelmenia G Ratliff						April 7, 1986						11:53PM		
3 SEX		4 RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR			IF UNDER 24 HRS		
Female		White		April 1 st 1924 th		61			MONTHS YRS			MONTHS DAYS HOURS MIN.		
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b CITIZEN OF WHAT COUNTRY?		8		MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH			MD.		
Washington DC		USA							Prince George					
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY		
Clinton			Southern Maryland Hospital						Housewife			Own Home		
13a. STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE			13f. ADDRESS	
Maryland			Pr George		Suitland		YES <input type="checkbox"/> NO <input type="checkbox"/>			3805 James Street			20746	
14. FATHER'S NAME			FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME			FIRST	MIDDLE	LAST			
			Harry	O	Scott				Sarah		King			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS					
No			578-92-9772			Earl F Ratliff			Same as #13					
18 CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c.)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Arrest</u>												1 hr		
DUE TO, OR AS A CONSEQUENCE OF (b) _____														
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause if any.														
DUE TO, OR AS A CONSEQUENCE OF (c) _____														
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a: <u>Hypertension</u>														
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
									YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM ETC.)			21f. LOCATION STREET _____ CITY OR TOWN _____ COUNTY _____ STATE _____								
22a. I certify that (I) <u>the hospital</u> attended the deceased from <u>Dec 12, 1985</u> to <u>4-7-1986</u> , that (we) lost saw the deceased alive on <u>4-7-1986</u> , and that in <u>(our)</u> opinion death occurred on the date and hour and from the causes stated above, <u>(we) (did) (did not)</u> view the body after death.												22c. DATE SIGNED <u>4/8/86</u>		
22d. SIGNATURE <u>Bernard Katzen M.D.</u>												DEGREE		
22e. PHYSICIAN'S NAME (TYPE OR PRINT)			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22f. ADDRESS <u>2645 - Neylor Rd. S.E. Washington, D.C.</u>								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE <u>11 April 1986</u>			23c. NAME OF CEMETERY OR CREMATORIAL <u>Cedar Hill Cemetery Suitland, MD.</u>			23d. LOCATION CITY OR TOWN <u>Suitland</u> COUNTY <u>MD</u>					
24 FUNERAL DIRECTOR NAME <u>Robert E Wilhelm</u>			ADDRESS <u>Suitland, Md.</u>			25a. DATE REC'D. BY REGISTRAR <u>PR 15 1986</u>			25b. REGISTRAR'S SIGNATURE <u>J. K. Wilhelm</u>					
Burial														
Funeral Home														



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												
8 REC. NO. 1 2 3 4 7												
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE			LAST			20. DATE OF DEATH	MONTH	DAY	YEAR
HELEN						RAWLINGS			04-08-86			
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		
F		B		MONTH DAY YEAR			65			IF UNDER 24 HRS		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGE'S COUNTY			MD.		
Md.		U.S.A.										
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY					
CHEVERLY		PRINCE GEORGE'S GENERAL HOSPITAL		HOUSEWIFE								
13a. STATE Md 13b. COUNTY P.G 13c. CITY OR TOWN CHEVERLY 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 13e. STREET ADDRESS / ZIP CODE 1077 Largo Rd Upper Marlboro 20772												
14. FATHER'S NAME FIRST		MIDDLE		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST								
Joe				Claudel						Simms		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT			ADDRESS			APPROXIMATE INTERVAL BETWEEN DEATH AND CERTIFICATION		
No				Raymond R. Rawlings / 1077 Largo Rd Upper Marlboro 20772								
18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac arrest (myocardial infarction)</u> DUE TO, OR AS A CONSEQUENCE OF <u>Untreated hypertension</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Acute myocardial infarction</u> DUE TO, OR AS A CONSEQUENCE OF <u>Untreated Hypertension</u> (c) <u>Untreated Hypertension</u>												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. <u>Ischemic cardiomyopathy, renal failure, Infective CHF</u>												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?				
					YES <input type="checkbox"/> NO <input type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from _____ 19_____, to _____ 19_____, that (I) (we) last saw the deceased alive on _____ 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.												
22b. SIGNATURE <u>Glen R. Tencin</u>		22c. DEGREE <u>M.D.</u>			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22d. DATE SIGNED <u>4/15/86</u>				
22e. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Glen R. Tencin</u>		22f. ADDRESS <u>9450 Penn. Ave. #18 Upper Marlboro MD 20772</u>										
23a. BURIAL, CREMATION, REMOVAL (SPECIES)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN COUNTY STATE					
BURIAL		April 12, 1986		Chews Chapel			Owensville AA Md					
24. FUNERAL DIRECTOR NAME		ADDRESS			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE				
William Reese & Sons Mortuary Anna Md		821 West St			APR 15 1986							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed until 22 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked show any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

1 - FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

86
REG. NO.

2348

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR	P		
Derelda			E.	RECORD		April	24	1986	5:15	M			
3 SEX		4. RACE	5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR # UNDER 24 HRS				
FEMALE		WHITE	FEB. 23. 1907			79			MONTHS DAYS HOURS MIN.				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE/CITY OR COUNTY OF DEATH							
OHIO		Leland Memorial Hospital				Prince George's MD.							
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY					
Riverdale		Leland Memorial Hospital			HOMEMAKER			AT HOME					
13a. STATE		13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE						
MD		PR GEO.	BELTSVILLE				11813 MACON ST. 20705						
14. FATHER'S NAME		FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME								
				CRAVO									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT			ADDRESS			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
NO		578-01-1386		EDWARD J. RECORD, 11813 MACON ST. BELTSVILLE						One week			
18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c.) PART I. DEATH WAS CAUSED BY:		IMMEDIATE CAUSE (a)			DUE TO, OR AS A CONSEQUENCE OF (b) Acute myocardial infarction						One week		
					DUE TO, OR AS A CONSEQUENCE OF (c) Arteriosclerotic cardiovascular disease						Unknown		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY	STATE	
22a. I certify that (I) (this hospital) attended the deceased from 4 August 1973 to 24 April 1986, that (I) (we) last saw the deceased alive on 24 April 1986, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE		CARL J. HOUmann			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED		
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		Carl J. Houmann, M. D.			22e. ADDRESS			4404 Queensbury Rd., Riverdale, MD 20737			24 April 1986		
23a. BURIAL, CREMATION, REMOVAL (TYPE OR PRINT)		23b. DATE April 28, 1986			23c. NAME OF CEMETERY OR CREMATORIAL Takoma Funeral Home			23d. LOCATION Rockville, Md.					
24. FUNERAL DIRECTOR NAME		254 Carroll St. N. W. D.			25a. DATE REC'D. BY REGISTRAR C APR 28 1986			25b. REGISTRAR'S SIGNATURE Julia L. Houmann					
BP _____													
DHMH - 16 50M 4/83 (VRA 15, 4)													

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of the death.

Page 4 may be

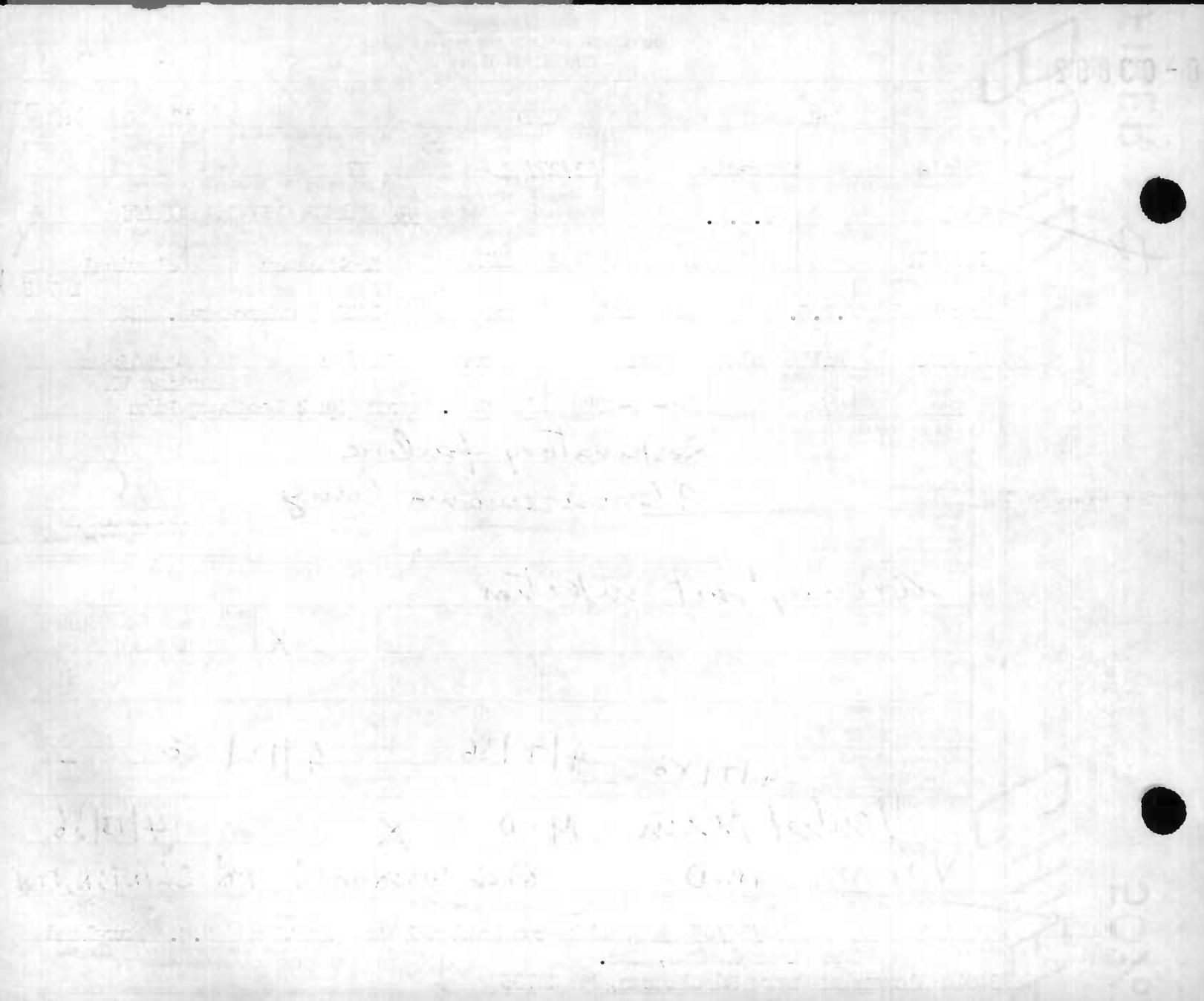
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use on the burial permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 24 hours of the death.

with the State Board of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or if item 18 shows any injury or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 12349			
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR		
kathleen E REED						11/27/86	4	12	86	3:38pm			
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR			
Female		Caucasian		11/27/08			77 YRS			MONTHS DAYS			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			IF UNDER 24 HRS			
Maryland		U.S.A.					PRINCE GEORGES COUNTY MD.			MONTHS HOURS MIN.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)								12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			
CLINTON		SOUTHERN MARYLAND HOSPITAL								Bookkeeper Clerical			
13a. STATE 13b. COUNTY 13c. CITY OR TOWN 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>												13e. STREET ADDRESS / ZIP CODE	
Maryland P.G.		Oxon Hill		1421 Southern Ave. #201			20745						
14. FATHER'S NAME FIRST		MIDDLE	LAST	15. MOTHER'S MAIDEN NAME Anne Louise Rawlings			ADDRESS						
Albert Billingsley Moran							Sterling VA						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT			18. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH						
No N/A		579-07-0388		Albert E. Moran									
18. CAUSE OF DEATH (Enter only one cause per line for 1a, (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory failure</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Adenocarcinoma lung</u>												LAST	
DUE TO, OR AS A CONSEQUENCE OF (c) _____													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a <u>Urinary tract infection</u>													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?						
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM ETC.)		21f. LOCATION STREET			CITY OR TOWN	COUNTY	STATE				
22a. I certify that (I) (this hospital) attended the deceased from 4/17/86 to 4/12/86, that (I) (we) last saw the deceased alive on 4/17/86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE		22c. DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22d. DATE SIGNED						
Venkat Main M.D.							4/13/86						
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS											
V. Main M.D.		8926 Woodyard Rd. CLINTON, Md.											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN		COUNTY		STATE		
Burial		04/16/86		Washington National Cem.			Suitland		P.G.		Maryland		
24. FUNERAL DIRECTOR NAME		Lee Funeral Home, Inc.		25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE						
6613 Old Alexander Ferry Rd Clinton, Md 20735				APR 17 1986			John Anderson - Pendleton						
DHMH - 16 50M 4/B3 (VRA 15, 4)													



00-03316

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 2350

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18, AND TO THE FUNERAL DIRECTOR, PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORMS PM 1 AND PM 2. RETAIN PAGE 5 FOR YOUR FILE. AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

1 - STATE REGISTRAR

DECEASED NAME
(TYPE OR PRINT)

FIRST

MIDDLE

LAST

2a. DATE KNOWN
OF
ESTI.
DEATH MATEDMONTH DAY YEAR
4-6-86 192b. HOUR
M.H.R.
10:15

DARIN

REVIS

3. SEX

4. RACE

Male

Caucasian

5. DATE OF BIRTH

MONTH DAY

YEAR

6. AGE (IN YEARS)
(LAST BIRTHDAY)

MONTHS DAYS

7. IF UNDER 1 YR.

8. IF UNDER 24 HRS.

MONTHS

DAYS

HOURS

MIN.

7a. BIRTHPLACE
(STATE OR
FOREIGN COUNTRY)

Washington

D.C.

U.S.A.

7b. CITIZEN OF WHAT COUNTRY?

8.

MARRIED NEVER MARRIED WIDOWED DIVORCED 9. DATE PRONOUNCED
DEAD

MONTH

DAY

YEAR

4-6-86

19

2d. HOUR
M.H.R.
10:15

10. CITY OR TOWN OF DEATH

Clinton

11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION

wooded area dead end of
Golden Drive

12a. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE ADDRESS BEFORE ADMISSION)

13a. STATE

Maryland

13b. COUNTY

P.G.

13c. CITY OR TOWN

Clinton

13d. INSIDE CITY LIMITS?

XX YES NO

13e. STREET ADDRESS

8800 Dangerfield Road 20735

14. FATHER'S NAME

First

L.

Middle

Last

Revis Jr.

15. MOTHER'S MAIDEN NAME

First

Joan

Middle

Last

Penn

16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES)

No

N/A

16b. SOCIAL SECURITY NO.

217-94-8128

17. INFORMANT

Homer L. Revis Jr. Same as 13 A-E

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Shotgur wound of head

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which
gave rise to immediate
cause (a) stating the under-
lying cause last.

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?

20. AUTOPSY?
(HEAD ONLY)
YES NO 21a. EXTERNAL CAUSE WAS
UNDERLYING OR
CONTRIBUTING CAUSE OF DEATH21b. INJURY OCCURRED
8 AM 4-6-86

P.M.

DAY

YEAR

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

self/inflicted

21d. INJURY OCCURRED
WHILE NOT WHILE
AT WORK21e. PLACE OF INJURY (AT HOME,
STREET, FACTORY, FARM, ETC.)

wooded area

21f. LOCATION

STREET

CITY OR TOWN

COUNTY

Clinton, Maryland

STATE

22a. I certify that I took charge of the remains described in Part 1 (a) and (b). (HEAD ONLY) Autopsy Inspection Inquiry and in my opinion
death resulted from: Natural causes Accident Suicide Homicide Undetermined manner ACTUAL
SIGNATURE

Margarita A. Korell, M.D.

M.D. Assistant MEDICAL EXAMINER

DATE
SIGNED 4-7-86EXAMINER'S NAME
(TYPE OR PRINT)

Margarita A. Korell, M.D.

ADDRESS
111 Penn Street23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)

23b. DATE

23c. NAME OF CEMETERY OR CREMATORY

23d. LOCATION
CITY OR TOWN

COUNTY

P.G.

STATE
Maryland

Burial

04/09/86

Washington National Cem.

Suitland

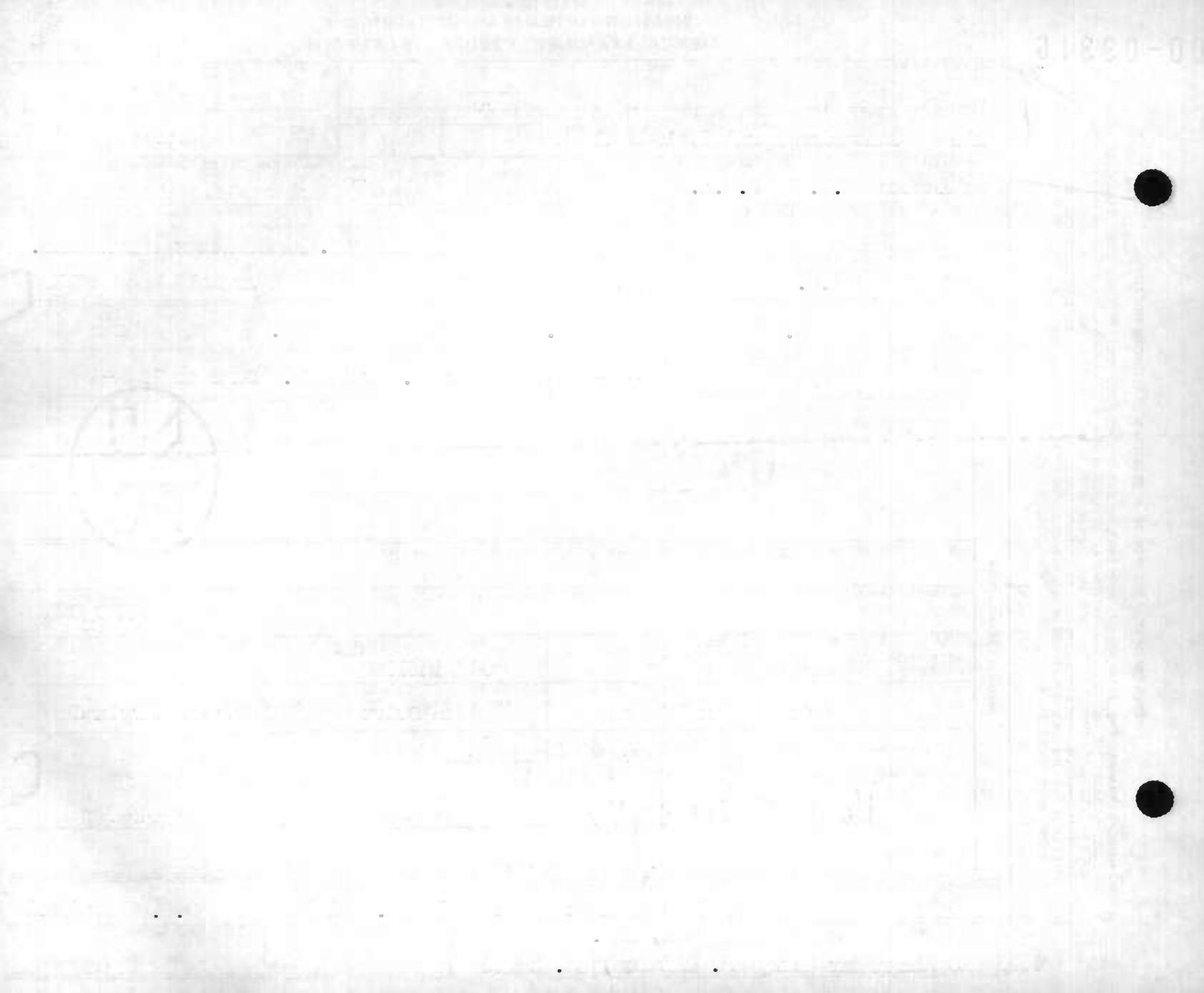
24. FUNERAL DIRECTOR
NAME

Lee Funeral Home, Inc.

25a. DATE REC'D. BY REGISTRAR

25b. REGISTRAR'S SIGNATURE

APR 11 1986



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18 LINE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGE 1 AND 2 SHOULD BE FILLED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO. 2351			
1 - STATE REGISTRAR UNKN. 86-31															
1. DECEASED NAME (TYPE OR PRINT)				FIRST		MIDDLE		LAST		2a. DATE KNOWN OF EST. DEATH MATED		2b. MONTH DAY YEAR			
Julio Cesar Reyes										<input checked="" type="checkbox"/>		4/7/1986			
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		2c. DATE PRONOUNCED DEAD			
MALE		CUBAN		8-26-42		43 yrs.						4/7/1986 A M			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)				7b. CITIZEN OF WHAT COUNTRY?				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH			
CUBAN				CUBAN								Prince George's County, MD.			
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS* OR INDUSTRY			
Langley Park				1423 Kanawa St.				Labour				Construction			
13. STATE				14. COUNTY				13e. CITY OR TOWN				13e. STREET ADDRESS			
MARYLAND				PRINCE GEO. HYATTSVILLE								311 Domer Ave 20783			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES, OR <input type="checkbox"/> UNKNOWN <input checked="" type="checkbox"/> NO				16b. SOCIAL SECURITY NO.				17. INFORMANT				ADDRESS			
				571-04-7671				Nelly Reyes-311 Domer Ave							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: 888 IMMEDIATE CAUSE (a) Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause lost. (b) DUE TO, OR AS A CONSEQUENCE OF (c)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I Chronic Alcoholism															
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?							
								<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO							
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR ? P.M. 4/7/1986				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) subject fell							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) laundry room				21f. LOCATION STREET CITY OR TOWN 1423 Kanawa St., Lankley Park, Pr. Geo., Md.							
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>				Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion											
ACTUAL SIGNATURE				TITLE (SPECIFY) M.D. Assistant				MEDICAL EXAMINER				DATE SIGNED 4/8/86			
EXAMINER'S NAME (TYPE OR PRINT)				Gregory R. Kauffman, M.D.				ADDRESS 111 Penn St.							
23a. BURIAL, CREMATION, REMOVAL				23b. DATE 4-12-86				23c. NAME OF CEMETERY OR CREMATORIAL Harmony Park				23d. LOCATION CITY OR TOWN Lanidore, Md.		STATE	
24. FUNERAL DIRECTOR NAME Vann & Williams				ADDRESS 4804 9A Ave. N.W.				25a. DATE REC'D. BY REGISTRAR APR 17 1986				25b. REGISTRATION NUMBER John Davidson			
(VR A15 ME (5))															

125-11-00

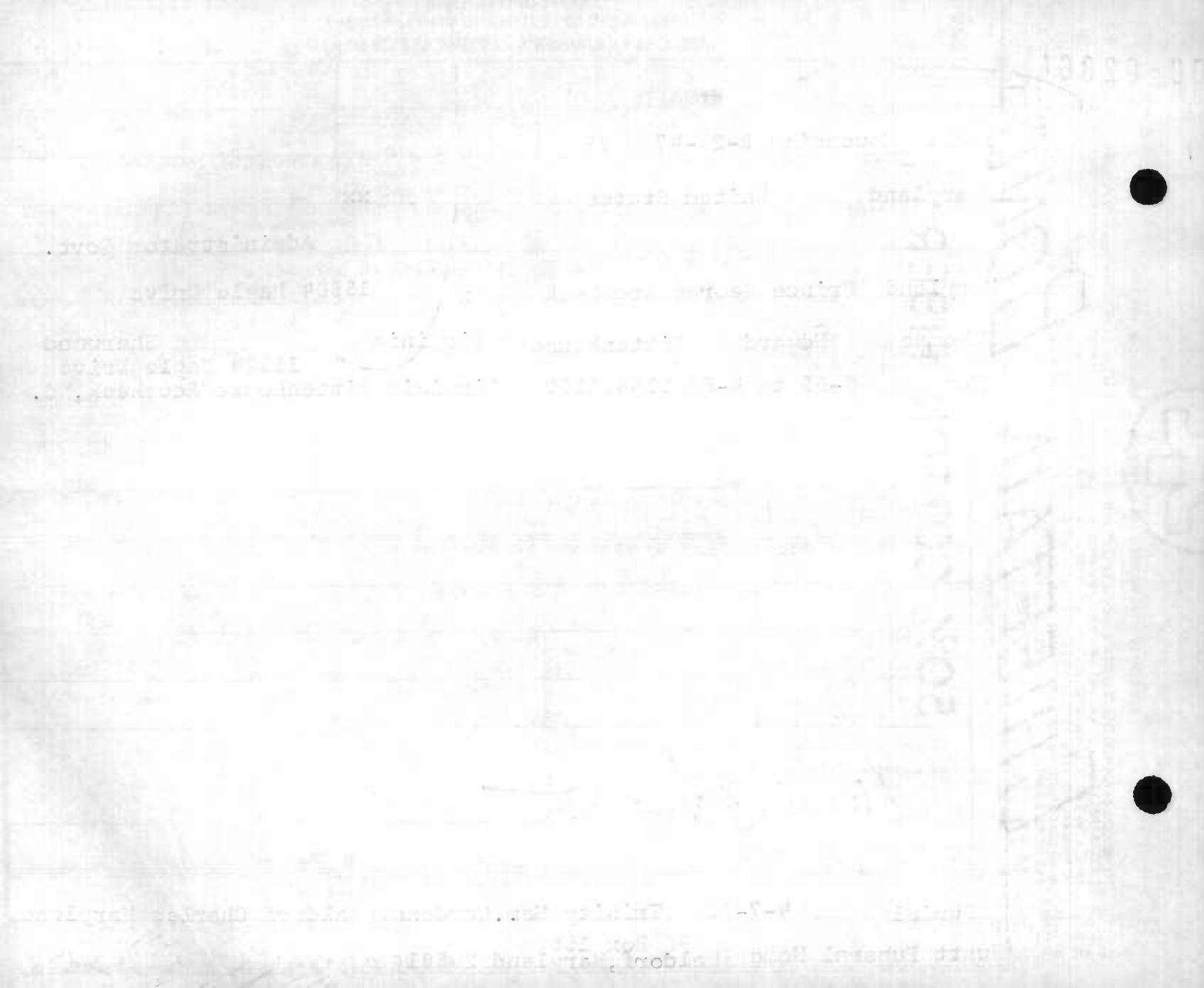
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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PAGE 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO. 1 2 3 5 2	
1- STATE REGISTRAR		DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE KNOWN <input checked="" type="checkbox"/> MONTH DAY YEAR OF ESTI- DEATH MATED <input type="checkbox"/> 4 3 1986			2b. HOUR M 2d HOUR 2:50 AM		
		JAMES EDWARD RITTENHOUSE											
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	7. IF UNDER 1 YR. MONTHS DAYS	8. IF UNDER 24 HRS. HOURS MIN.	2c. DATE PRONOUNCED DEAD MONTH DAY YEAR 4 3 1986					
Male Caucasian		8-25-47		38 yrs.									
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's County MD.					
Maryland		United States											
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY					
Oxon Hill		Northbound I-95 no. of Indian Head Hwy. Administrator Govt.									20607		
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 15504 Maple Drive					
Maryland		Prince George Accokeek											
14. FATHER'S NAME FIRST		MIDDLE		LAST	15. MOTHER'S MAIDEN NAME FIRST		16. ADDRESS 15504 Maple Drive		Sherwood				
Thomas		Edward		Rittenhouse	Virginia		Virginia Rittenhouse Accokeek, Md.						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES)		16b. SOCIAL SECURITY NO.			17. INFORMANT								
Yes 9-65 to 4-69		214488169											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Multiple injuries</u> DUE TO, OR AS A CONSEQUENCE OF { Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY?								
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 1:40xx 4-3- 1986			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) Subject laid down on highway & was passed			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) road			21f. LOCATION STREET N/B I-95 no. of Indian Head Hwy., Prince George			CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <u>Dennis F. Smyth, M.D.</u> TITLE (SPECIFY) M.D. Assistant MEDICAL EXAMINER												MD	
EXAMINER'S NAME (TYPE OR PRINT)		Dennis F. Smyth, M.D.			ADDRESS 111 Penn St., Balto., MD 21201			DATE SIGNED 4-3-86					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE 4-7-86		23c. NAME OF CEMETERY OR CREMATORIAL Trinity Mem. Gardens			23d. LOCATION CITY OR TOWN Waldorf		COUNTY Charles		STATE Maryland		
24. FUNERAL DIRECTOR NAME Huntt Funeral Home		ADDRESS PO Box 156 Waldorf, Maryland 20601			25a. DATE REC'D. BY REGISTRAR APR 08 1986			25b. REGISTRAR'S SIGNATURE <u>Julia Tevidor, Reg. No. 1000</u>					
BP _____													
DHMH - 17 (VR A15 ME (5))													

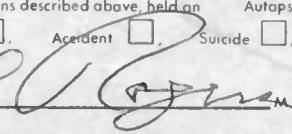
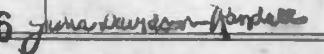


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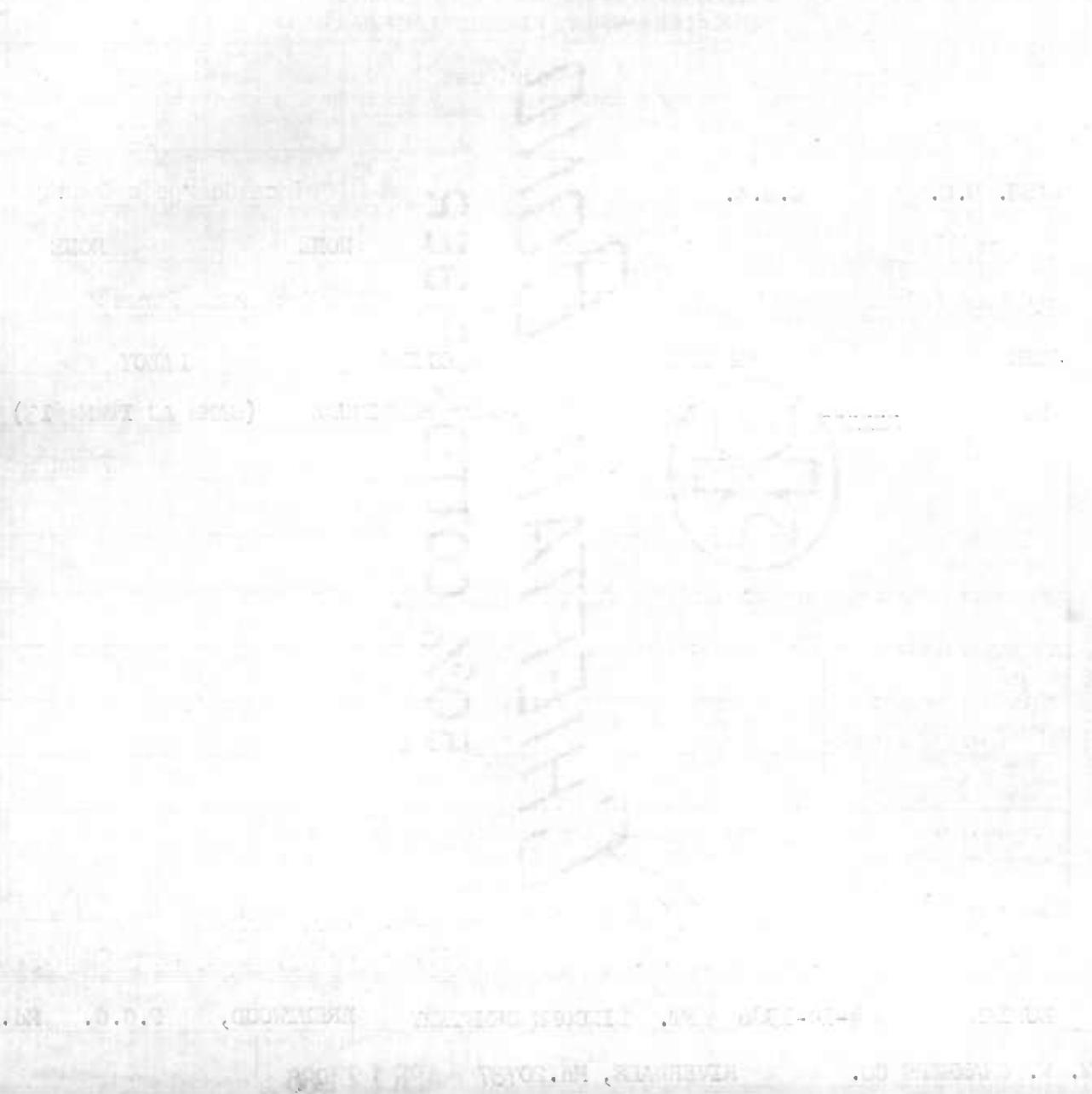
TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. RETAIN PAGE 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILLED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 21201 PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. J 2 3 5 3

1- STATE REGISTRAR		2a. DATE KNOWN OF ESTI- DEATH MATED <input checked="" type="checkbox"/> 4/11 1986														
1. DECEASED NAME (TYPE OR PRINT)		FIRST			MIDDLE		LAST			YEAR	3:45					
Melissa							Rodriguez				P.M.					
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY) YRS.		7. IF UNDER 1 YR. MONTHS DAYS		8. IF UNDER 24 HRS. HOURS MIN		7c. DATE PRONOUNCED DEAD MONTH DAY YEAR	3:45					
Female	White	Apr. 17, 1980		5						4/11 19 86	P.M.					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>		WIDOWED <input type="checkbox"/>		DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH						
WASH. D.C.		U.S.A.								Prince George's County						
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)										12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY			
Hyattsville		2003 Tuckerman Street										NONE	NONE			
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS								
Maryland		Prince George's		Hyattsville				2003 Tuckerman Street		20782						
14. FATHER'S NAME FIRST		MIDDLE		LAST		15. MOTHER'S MAIDEN NAME FIRST		MIDDLE		LAST						
JOSE				RODRIGUEZ		AQUILINA				LABOY						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <input type="checkbox"/> NO		(YES, NO, OR UNKNOWN) <input type="checkbox"/> NO		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS								
				-----		JOSE RODRIGUEZ		(SAME AS ITEM #13)								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Brain tumor. DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 7 months				
(b) DUE TO, OR AS A CONSEQUENCE OF																
(c)																
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) None																
19a. DATE OF OPERATION None		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?										20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)		21d. LOCATION STREET		CITY OR TOWN		COUNTY		STATE				
21e. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21f. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21g. LOCATION STREET												
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>												Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion				
ACTUAL SIGNATURE 												TITLE (SPECIFY) Deputy MEDICAL EXAMINER 1919 Seminary Road ADDRESS Silver Spring, Montgomery County, Md.				
EXAMINER'S NAME (TYPE OR PRINT)		23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL										23b. DATE 4-14-1986	23c. NAME OF CEMETERY OR CREMATORIAL FT. LINCOLN CEMETERY	23d. LOCATION CITY OR TOWN BRENTWOOD,	23e. COUNTY P.G.C.	STATE Md.
24. FUNERAL DIRECTOR NAME W. W. CHAMBERS CO.		ADDRESS RIVERDALE, Md. 20737		25a. DATE REC'D. BY REGISTRAR APR 17 1986		25b. REGISTRAR'S SIGNATURE 										
07/84 25M		DHMH - 17 (VR A15 ME (5))														

10000-0



TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or if Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 12354

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR
<i>Leonard Thomas Roland, Sr.</i>						04	26	86		11:25 am
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)				
Male		Caucasian		MONTH March	DAY 24	YEAR 1901	85			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8.		9. BALTIMORE CITY OR COUNTY OF DEATH				
Maryland		U.S.A.		MARRIED <input checked="" type="checkbox"/>	NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/>	DIVORCED <input type="checkbox"/>	PRINCE GEORGES		MD.
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY				
CLINTON		Southern Maryland Hospital		Locksmith - Ret.		U.S. Post Office				
13a. STATE		13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE		20744		
Maryland		Prince George	Friendly	Lillie		10303 Roland Lane				
14. FATHER'S NAME		FIRST Alton	MIDDLE P.	LAST Roland	15. MOTHER'S MAIDEN NAME		MIDDLE		LAST White	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR ORDATES)		17. INFORMANT		ADDRESS				
No		578-09-0877		Hattie Thorne Roland Friendly, Maryland		10303 Roland Lane				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Aortic Anomaly Dissection</i> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH										
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause, if any. (b) <i>& cardio respiratory failure</i>										
DUE TO, OR AS A CONSEQUENCE OF (c)										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
4/24/86		Aortic Anomaly				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART I OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY	STATE	
22a. I certify that (I) this physician attended the deceased from 4/25/86 to 4/24/86, and that in (my) <input checked="" type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above, (I) <input checked="" type="checkbox"/> did not view the body after death.										
22b. SIGNATURE <i>BSG Rover</i>		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/>		MEDICAL DIRECTOR <input type="checkbox"/>		STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED 4/26/86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>BSG Rover</i>		22e. ADDRESS 7501 Smith Rd #104								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE 4/30/86		23c. NAME OF CEMETERY OR CREMATORY St. John's Epis. Ch. Com.		23d. LOCATION CITY OR TOWN Ft. Washington P.G. Maryland		23e. COUNTY Maryland		
Burial		4/30/86		St. John's Epis. Ch. Com.		Ft. Washington P.G. Maryland				
24. FUNERAL DIRECTOR <i>George P. Kalas Funeral Home</i>		ACCDN 6160 Oxon Hill Rd. Oxon Hill, Md.		25a. DATE REC'D. BY REGISTRAR APR 29 1986		25b. REGISTRAR'S SIGNATURE <i>unreadable signature</i>				

Mr. G. A. Smith, Concessions Manager, 59-1821

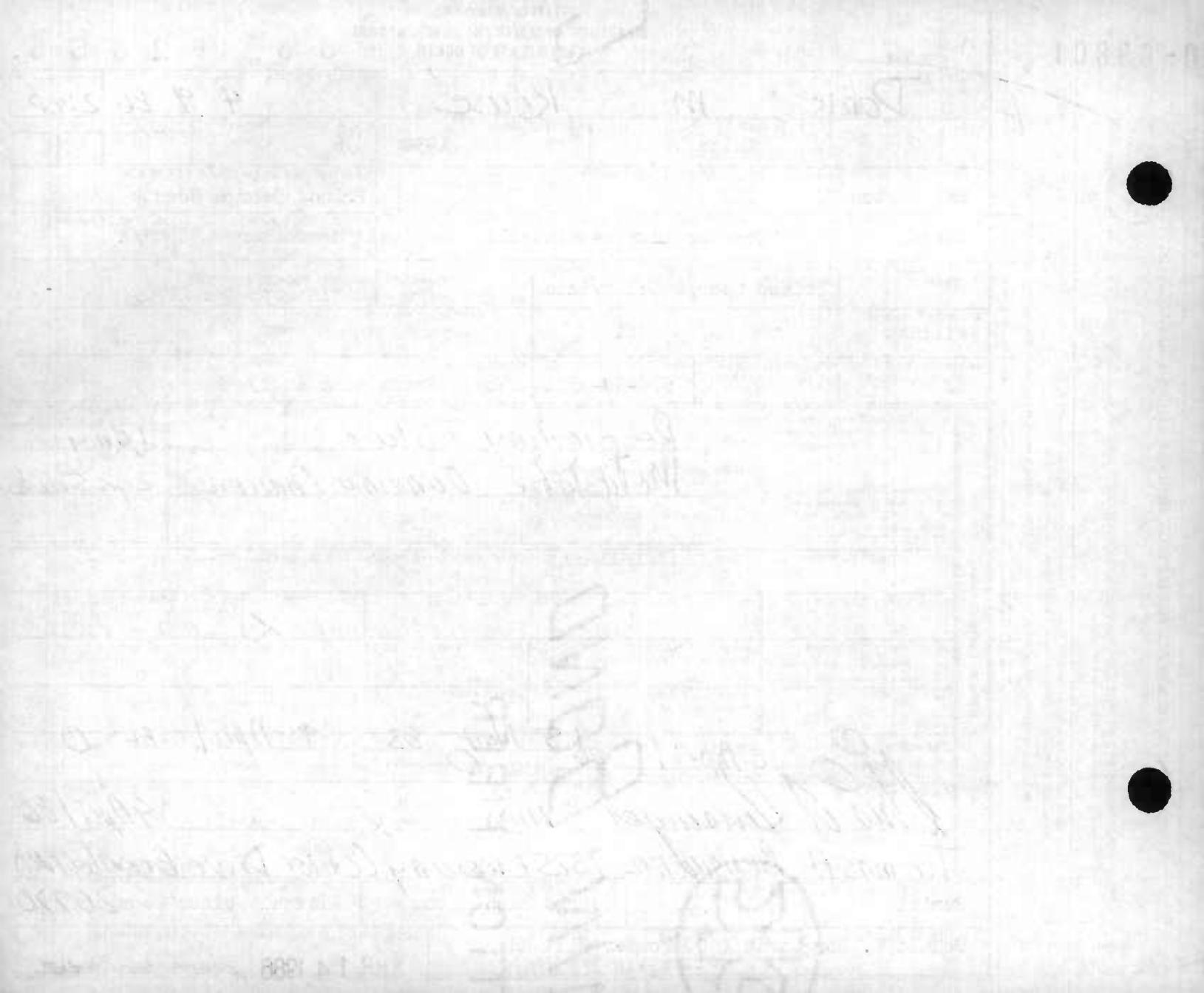
0-03801

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO. 86112355	
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR			
Doris			M		Rouse	4 9	86			2:45P M			
3. SEX		4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR		IF UNDER 24 HRS					
F		White	MONTH	8 DAY	56	MONTHS	DAYS	HOURS	MIN.				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince George County							
Washington DC		USA											
10. CITY OR TOWN OF DEATH Laurel		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION Greater Laurel Beltsville Hospital				12a. USUAL OCCUPATION (TYPE WORK OR LEISURE WORKING LIFE) Homemaker							
						12b. KIND OF BUSINESS OR INDUSTRY N/A							
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)													
13a. STATE Md		13b. COUNTY Prince George		13c. CITY OR TOWN Beltsville		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 10407C 46th Ave 20705					
14. FATHER'S NAME William		MID M		GIRL		15. MOTHER'S MAIDEN NAME Dorothy		16. ADDRESS Edwards					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? NO		16b. SOCIAL SECURITY NO. 578-38-8391		17. INFORMANT George Rouse same as 13									
18. CAUSE OF DEATH (ENTER ONLY ONE CAUSE PER LINE FOR (a), (b), AND (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory Failure 1 day DUE TO, OR AS A CONSEQUENCE OF (b) Metastatic Ovarian Cancer 2 yrs 5 months Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c)													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE			
22a. I certify that (I) (this hospital) attended the deceased from 15 Nov 83 to 9 April 1986, that (I/we) last saw the deceased alive on 19 86, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I/we) did not view the body after death.													
22b. SIGNATURE Thomas A. Bensinger MD		22c. DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/>		MEDICAL DIRECTOR <input type="checkbox"/>		STAFF PHYSICIAN <input type="checkbox"/>		DATE SIGNED 9 April 1986			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Thomas A. Bensinger		22e. ADDRESS 7525 Greenway Center Drive Gaithersburg MD 20878											
23a. BURIAL, CREMATION, REMOVAL Burial		23b. DATE 4/12/86		23c. NAME OF CEMETERY OR CREMATORIAL George Washington		23d. LOCATION Adelphi Prince George 20780							
24. FUNERAL DIRECTOR Donald V. Borgwardt		4400 Powder Mill Rd Beltsville MD 20705		25a. DATE REC'D. BY REGISTRAR APR 14 1986		25b. REGISTRAR'S SIGNATURE John J. Dawson							



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon-papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												
8 6 REG. NO. 1 2 3 5 6												
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2d. DATE OF DEATH MONTH DAY YEAR			2b. HOUR			
MATILDA E. RUFFIN						04-21-86			7 :17AM M			
3. SEX			4. RACE		5. DATE OF BIRTH MONTH DAY		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS	
Female			Black		Apr. 2, 1902		84 YRS.		MONTHS DAYS		HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGE'S MD.					
MD			USA									
10. CITY OR TOWN OF DEATH CHEVERLY			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION PRINCE GEORGE'S GENERAL HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife			12b. KIND OF BUSINESS OR INDUSTRY				
13a. STATE MD			13b. COUNTY Pr. Geo.		13c. CITY OR TOWN Seat Pleasant		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE 6233 Addison Road/ 20743		
14. FATHER'S NAME FIRST Otho Simms			MIDDLE		LAST	15. MOTHER'S MAIDEN NAME Sarah M. Sewell			ADDRESS			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT Thelma Washington, same as #13			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
No			577-32-2507									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Breast Renal Failure</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Diabetes mellitus.</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Breast Carcinoma.</u>												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)												
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
							YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET			CITY OR TOWN		COUNTY	STATE	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not view the body after death.												
22b. IN SIGNATURE <u>Samuel E. Toney</u> DEGREE												
22c. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			22d. DATE SIGNED									
22e. ADDRESS												
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL		23d. LOCATION CITY OR TOWN		COUNTY		STATE	
Burial			4-25-86		Lincoln Park Cem.		Rockville, Montg. MD					
24. FUNERAL DIRECTOR NAME			246 N. Washington		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
George R. Snowden			Rockville, MD 20850		APR 30 1986		<u>John T. Toney</u>					
BP_____												
DHMH - 16 60M 7/84 (VRA 15, 4)												

00570-00

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00-04521

1-
FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH8 6
REG. NO.

1 2 3 5 7

1 DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	20 DATE OF DEATH	MONTH	DAY	YEAR	2b HOUR	
			EDOARDO	SACCHI		04-17-86	12	:15PM	M		
3 SEX		4 RACE		5. DATE OF BIRTH MONTH DAY YEAR			6 AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		
Male		White		9	11	20	65	YRS	MONTHS	DAYS	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGE'S COUNTY MD.				
Italy		U.S.									
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION IF NURSING HOME OR OTHER INSTITUTION, GIVE ADDRESS		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b KIND OF BUSINESS OR INDUSTRY				
CHEVERLY		PRINCE GEORGE'S GENERAL HOSPITAL		Director			State Agri-				
13a STATE		13b COUNTY		13c CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS / ZIP CODE		culture	
Md.		Pr. Geo.		College Pk.				4330 Hartwick Rd. 20740			
14. FATHER'S NAME FIRST		MIDDLE		LAST	15. MOTHER'S MAIDEN NAME FIRST		MIDDLE		LAST		
Mario				Sacchi	Carmela				Bergomi		
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		16c		17. INFORMANT		ADDRESS			
NO		578-42-1146									

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		immediate
{ DUE TO, OR AS A CONSEQUENCE OF (b) <i>urosepsis, wet gangrene</i>		7 days
{ DUE TO, OR AS A CONSEQUENCE OF (c)		

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a
uncontrolled diabetes mellitus, severe peripheral vascular disease

19a DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a AUTOPSY?	20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
		<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO

21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)
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21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f LOCATION STREET	CITY OR TOWN	COUNTY	STATE
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22a I certify that (I) (this hospital) attended the deceased from saw the deceased alive on <i>4/16</i> 19 <i>86</i> , to <i>4/17</i> 19 <i>86</i> , that (I) (we) last above (I) (we) did not view the body after death.	22b SIGNATURE <i>David Granite</i>	DEGREE	ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c DATE SIGNED <i>4/17/86</i>
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22d PHYSICIAN'S NAME (TYPE OR PRINT) <i>David Granite, MD</i>	22e ADDRESS <i>115 Counterway Greenbelt, MD</i>
--	--

23a BURIAL, CREMATION, REMOVAL (SPECIFY) Removal	23b DATE 4-17-86	23c NAME OF CEMETERY OR CREMATORIAL ADDRESS	23d LOCATION CITY OR TOWN	23e COUNTY	STATE
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24 FUNERAL DIRECTOR NAME Anatomy Board	25a DATE REC'D. BY REGISTRAR APR 24 1986	25b REGISTRAR'S SIGNATURE <i>Julie Davidson Pendleton</i>
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then attach to the burial or removal papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury or other traumatic event, the medical examiner must be notified.

BP

15240-00



00-04038

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8612358
REG. NO.

1 - STATE REGISTRAR			2a DATE OF DEATH MONTH DAY YEAR										2b HOUR	
1 DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE			LAST			04-16-86			8 :00AM		
VICTOR T. SALE														
3 SEX			4 RACE			5. DATE OF BIRTH MONTH DAY YEAR			6 AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		
Male			White			2 / 6 / 1916			70			MONTHS DAYS HOURS MIN.		
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b CITIZEN OF WHAT COUNTRY?			8			9 BALTIMORE CITY OR COUNTY OF DEATH			IF UNDER 24 HRS		
Virginia			U.S.A.			MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			PRINCE GEORGE'S COUNTY					
10 CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION			12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b KIND OF BUSINESS OR INDUSTRY					
CHEVERLY			PRINCE GEORGE'S GENERAL HOSPITAL			Truck Driver			Columbia Planographic					
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE		
Md.			P.G.			Landover						9108 Utica Place 20785		
14. FATHER'S NAME FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST											
Spilsby W. Sale			Mary E. Baker											
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES OR UNKNOWN)			16b SOCIAL SECURITY NO.			17 INFORMANT			ADDRESS			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
Yes WWII			577-24-7438			Victor T. Sale, Jr.			9108 Utica Pl.			Landover, Md.		
18 CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c) PART 1. DEATH WAS CAUSED BY			IMMEDIATE CAUSE (a)			Cardio pulmonary heart disease								
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last			DUE TO, OR AS A CONSEQUENCE OF + Peripheral vascular disease											
			DUE TO, OR AS A CONSEQUENCE OF + Ischemic Ulcer foot											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a Diabetes mellitus, Chronic End Stage Renal Disease.														
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?					
						YES <input type="checkbox"/> NO <input type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY STATE		
22a I certify that (I) (this hospital) attended the deceased from saw the deceased alive on 4/16/86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			3/24/1986, 10 4/16/1986											
22b. SIGNATURE <i>James B. Sale</i>			22c. DEGREE M.D.			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22d. DATE SIGNED					
22e. PHYSICIAN'S NAME (TYPE OR PRINT)			22f. ADDRESS											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN			COUNTY STATE		
Cremation			4/16/86			Lee Crematory			Washington, D.C.					
24 FUNERAL DIRECTOR NAME Rendon/Hale Lanham Funeral Home 9013 Annapolis Rd. Lanham, Md. 20706						25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE					
									APR 18 1986					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as (b) it shows any injury, or other traumatic event, the medical examiner

10010-00

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11-10-66

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be detached for use as the burial transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as having shown any injury, or other traumatic event, the medical

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO. 8 6 1 2 3 5 9	
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	20. DATE OF DEATH			MONTH	DAY	YEAR	2b HOUR	
ESTELLE C. SARTOR						04-22-86						9:15AM	
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR	
Female			Black			Month Day Year April 12, 1903			83			YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			IF UNDER 24 HRS	
D.C.			U.S.A.						PRINCE GEORGES COUNTY			MONTHS DAYS HOURS MIN.	
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY				
CHEVERLY			PRINCE GEORGES GENERAL HOSPITAL			Homemaker			Own Home				
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE	
Md.			P.G. Fairmount Hgts									710 58th Ave. 20743	
14. FATHER'S NAME FIRST			MIDDLE			15. MOTHER'S MAIDEN NAME FIRST			LAST			ADDRESS	
Harry			Miles			Mary			Anderson			Fairmount Heights, Md	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES OR NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) possible sepsis			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
No													
16c. DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			(b) HCVDC multiple CVA's			16d. DUE TO, OR AS A CONSEQUENCE OF (c) urinary tract infection							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a vasculitis . CAD c old 78													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN	COUNTY	STATE		
22a. I certify that (I) (this hospital) attended the deceased from 4.22.1986 to 4.22.1986, that (I) (we) last saw the deceased alive on 4.22.1986, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death													
22b. SIGNATURE <i>H.A. Molave</i>			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 4.22.86				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) HASSAN A. MOLAVE			22e. ADDRESS 6005 Landover Rd. Cheverly										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE 4/26/86			23c. NAME OF CEMETERY OR CREMATORIAL MARYLAND NATL. CEM.			23d. LOCATION CITY OR TOWN BELTSVILLE, P.G. MD.			COUNTY STATE	
24. FUNERAL DIRECTOR NAME H. S. WASHINGTON & SONS			ADDRESS 4925 BURRONGHS AVE, N.E.			25a. DATE REC'D. BY REGISTRAR MAY 06 1986			25b. REGISTRAR'S SIGNATURE <i>J. Johnson</i>				

base camp
and return to
the last camp
in the morning.

23 25.00 28 13.00 23 60.00

18.55.00 X 100.00 100.00
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200.00 100.00 100.00 100.00

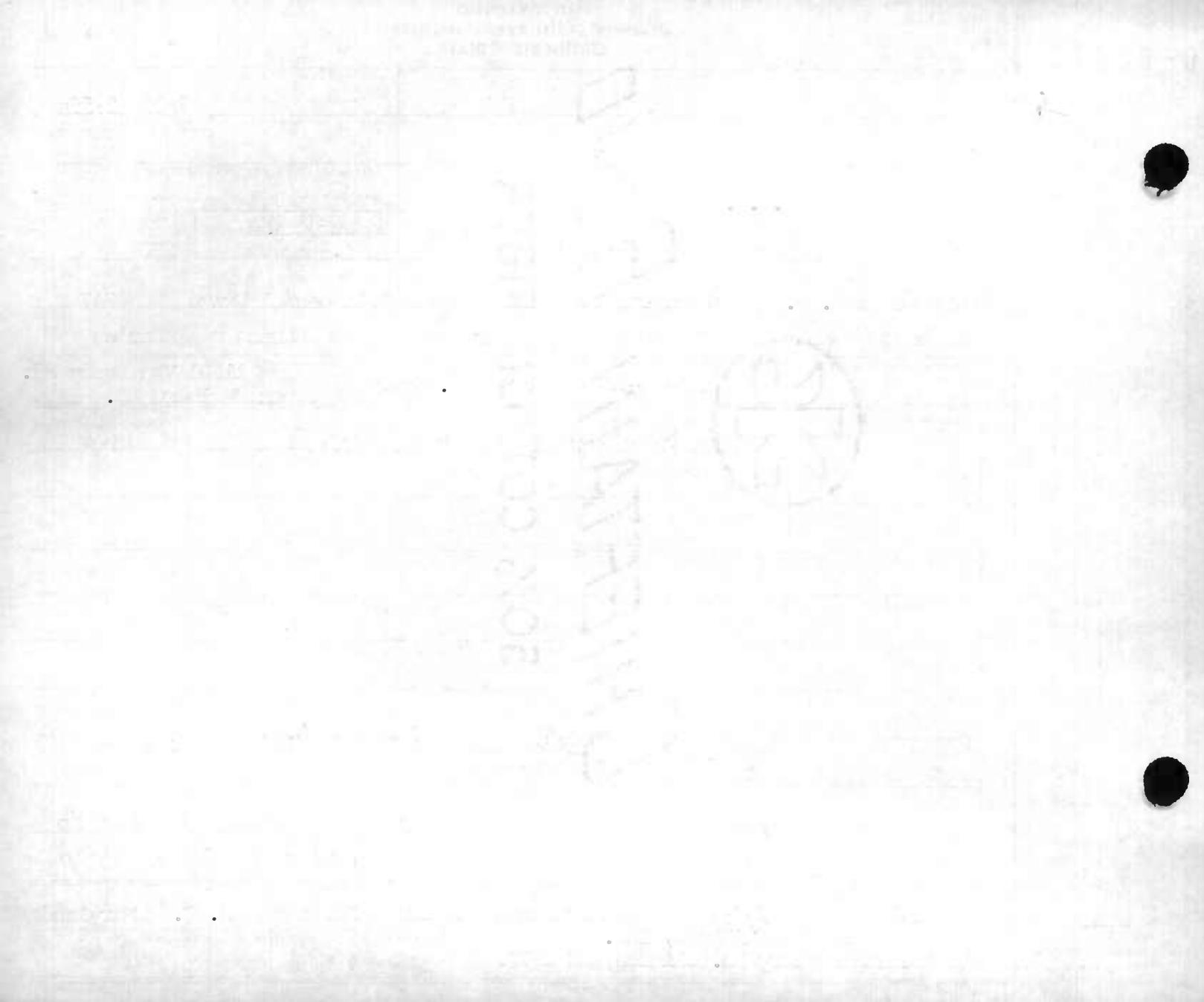
10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial transit permit. Then please remove carbon adipen. Forget, I need 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on Item 15, the injury injury, or other traumatic event, the medical examiner must be notified.

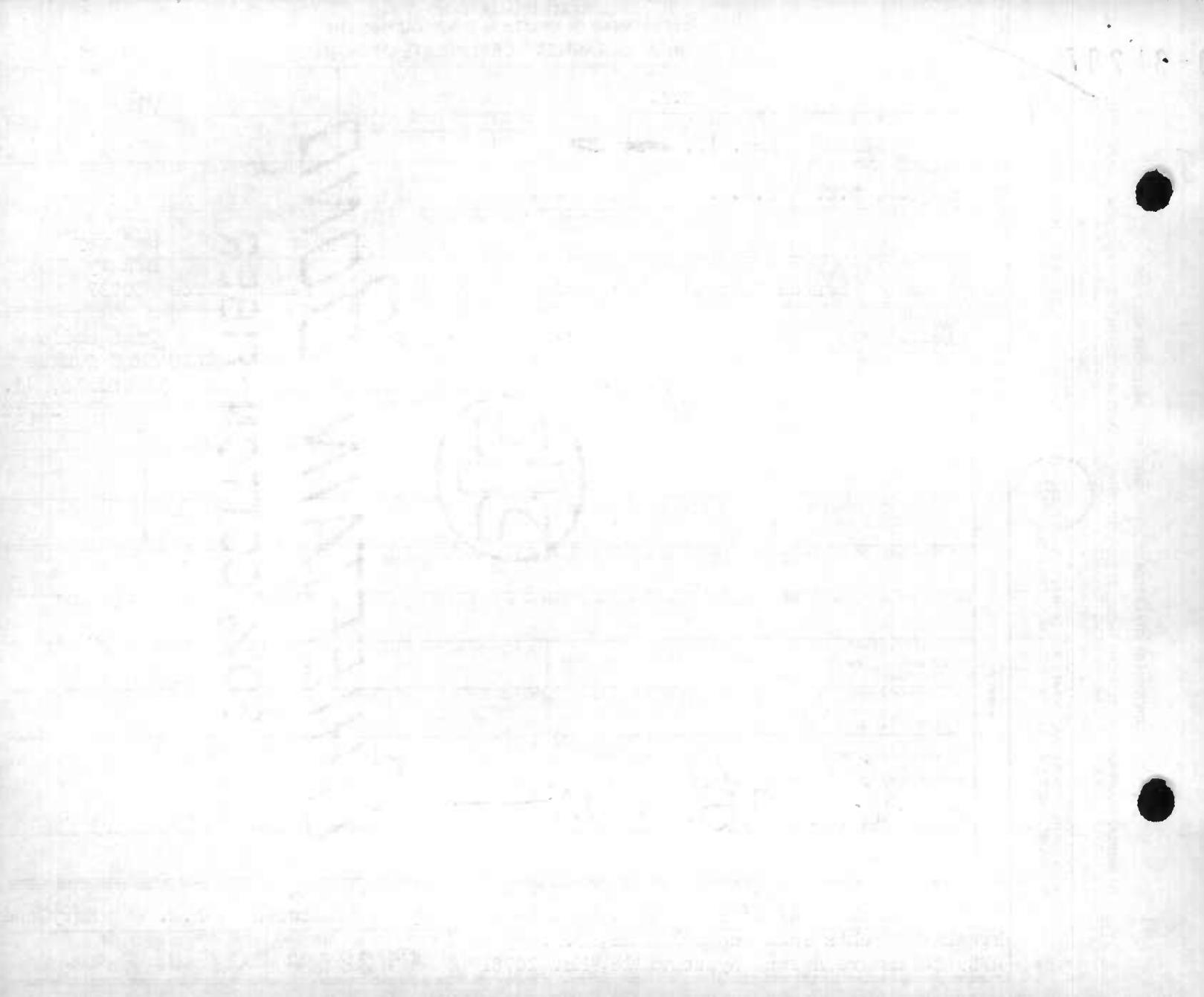
MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO. 8012360			
1 - FOR STATE REGISTRAR			1. DECEASED NAME FIRST JOHN R. SAVOY			LAST			2a. DATE OF DEATH 04 06 86			MONTH DAY YEAR	2b. HOUR 2:55a M		
3. SEX Male		4. RACE Black		5. DATE OF BIRTH MONTH June DAY 15, 1926 YEAR			6. AGE (IN YEARS LAST BIRTHDAY) 59 YRS			IF UNDER 1 YEAR		IF UNDER 24 HRS			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGES COUNTY MD			10. CITY OR TOWN OF DEATH CLINTON		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SAME FACILITY, GIVE STREET ADDRESS) SOUTHERN MARYLAND HOSPITAL CENTER			
12a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13a. STATE Maryland		13b. COUNTY P. G.		13c. CITY OR TOWN Forestville		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 7912 Daniel Drive 20747		12b. USUAL OCCUPATION Construction WORKING LIFE Estimator		12c. KIND OF BUSINESS OR INDUSTRY WSSC	
14. FATHER'S NAME George		FIRST MIDDLE Henry		LAST Savoy		15. MOTHER'S MAIDEN NAME Mary		16. WAS DECEASED EVER IN U.S. ARMED FORCES? NO (IF YES, GIVE WAR OR DATES) N/A		16b. SOCIAL SECURITY NO. 214-28-7608		17. INFORMANT Joseph L. Savoy		ADDRESS 11301 Van Brady Rd. Upper Marlboro Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchogenic Carcinoma, Stage III												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 mo			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)															
DUE TO, OR AS A CONSEQUENCE OF (c)															
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)															
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED								20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that (I) (this hospital) attended the deceased from March 19, 86, to April 19, 86, and that (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.															
22b. SIGNATURE Kai-Yin Yenw, MD												22c. DATE SIGNED 4-6-86			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Kai-Yin Yenw, MD		22e. ADDRESS 8926 Woodyard Rd # 201 Clinton MD 20735													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 04/09/86		23c. NAME OF CEMETERY OR CREMATORIAL Resurrection Cemetery			23d. LOCATION CITY OR TOWN Clinton			P. G. COUNTY Maryland STATE					
24. FUNERAL DIRECTOR Lee Funeral Home, Inc.		NAME ADDRESS 6633 Old Alexander Ferry Rd. Clinton, Md 20735		25a. DATE REC'D. BY REGISTRAR APR 11 1986			25b. REGISTRAR'S SIGNATURE Anderson								
DHMH - 16 60M 7/B (VRA 15, 4)															



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3, RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSFER FORM. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DIVISION OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

FOR 1 - STATE REGISTRAR		STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 2361	
		DATE KNOWN <input checked="" type="checkbox"/> OF ESTI- DEATH MATED <input type="checkbox"/>										2b. HOUR 4/18/19 86	
1. DECEASED NAME (TYPE OR PRINT)		FIRST Nicholas		MIDDLE F.A.		LAST Scaldaferri		2c. DATE PRONOUNCED DEAD 4/18/86 P M		MONT. DAY YEAR 7:40			
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Aug. 13, 1934		6. AGE (IN YEARS) 41 LAST BIRTHDAY 51 YRS.		7. IF UNDER 1 YR. MONTHS DAYS HOURS MIN.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington, D.C.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's County, MD.							
10. CITY OR TOWN OF DEATH Cheverly		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Prince George's General Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Shipper		12b. KIND OF BUSINESS OR INDUSTRY Safeway Bakery							
13a. STATE Maryland		13b. COUNTY Prince George's		13c. CITY OR TOWN Riverdale		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 6817 Beacon Place 20737					
14. FATHER'S NAME FIRST Nicola		MIDDLE Scaldaferri		15. MOTHER'S MAIDEN NAME FIRST Christina		MIDDLE LAST Piacquadio							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. 578-58-3501		17. INFORMANT Theresa Scaldaferri (Sister) Avondale, Md.		ADDRESS 4616 22nd Avenue							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Cardiovascular Disease								APPROXIMATE TIME BETWEEN ONSET AND DEATH 2012					
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.		{ DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		19c. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY STATE					
22a. I certify that I took charge of the remains described above, held an		Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/>		and in my opinion									
death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>													
ACTUAL SIGNATURE <i>Dennis F. Smyth, M.D.</i>		TITLE (SPECIFY) M.D. Assistant		MEDICAL EXAMINER		DATE SIGNED 4/19/86							
EXAMINER'S NAME (TYPE OR PRINT)		Dennis F. Smyth, M.D.		ADDRESS 111 Penn St.									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 4/23/86		23c. NAME OF CEMETERY OR CREMATORIUM Fort Lincoln Cemetery		23d. LOCATION CITY OR TOWN Brentwood		COUNTY P.G. STATE Maryland					
FUNERAL DIRECTOR NAME Francis Gasch's Sons Funeral Home, P.A. 4739 Baltimore Avenue Hyattsville, Md. 20781				25a. DATE REC'D. BY REGISTRAR APR 22 1986		25b. REGISTRAR'S SIGNATURE <i>Julie Davidson-Pondale</i>							
ADDRESS (VR A15 ME (5))													



Medical Examiner Notified & Released

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked "X" shows any injury, or other traumatic event, the medical examiner must be informed.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 0 1 2 3 6 2
										REG. NO.
1 - STATE REGISTRAR	FIRST	MIDDLE	LAST	2a DATE OF DEATH	MONTH	DAY	YEAR	2b HOUR		
1. DECEASED NAME (TYPE OR PRINT)	Dolores	B.	Schmidt	April 8, 1986				11:00 PM		
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR		IF UNDER 24 HRS.			
FEMALE	Caucasian	MONTH	JAN 17, 1919	YEAR	67	MONTHS	DAYS	HOURS MIN.		
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
PENNSYLVANIA	U.S.A.				Prince George's County					
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)					
Lanham	Doctor's Hosp. of Pr. Geo. Co.				MEDICAL RECEPTIONIST					
13a STATE	13b COUNTY	13c CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE					
MD	PRINCE GEORGE'S	CHEVERLY			5008 INWOOD STREET 20785					
14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME							
GEORGE BREECE			ELIZABETH BOY							
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES OR NO OR UNKNOWN)	16b SOCIAL SECURITY NO. (IF YES GIVE WAR OR DATES)	17. INFORMANT		ADDRESS						
NO	127-09-9514	JUDY L. DARVISH 13513 GLENMILL ROAD POTOMAC MD 20850								
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Massive acute cerebral hemorrhage</i>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
DUE TO, OR AS A CONSEQUENCE OF (b) <i>severe carotid atherosclerosis</i>										
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>occlusive coronary atherosclerosis</i>										
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?				
					YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET	CITY OR TOWN		COUNTY		STATE			
22a. I certify that (I) (this hospital) attended the deceased from <i>N/A</i> , 19 <i>N/A</i> , to <i>N/A</i> , 19 <i>N/A</i> , that (I) (we) last saw the deceased alive on <i>N/A</i> , 19 <i>N/A</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <i>Jerry B. Harmon, M.D.</i> DEGREE <i>MD</i>										22c. DATE SIGNED <i>4-9-86</i>
PHYSICIAN'S NAME (TYPE OR PRINT)					ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>					
Jerry B. Harmon, M.D.					Pathologist. Doctors' Hospital of Pr. Geo. Co. 8118 Good Luck Rd., Lanham					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS		23d. LOCATION CITY OR TOWN	COUNTY		STATE			
CREMATION	Apr. 10, 1986	Metropolitan Crematory		Alexandria	N/A		Virginia			
24. FUNERAL DIRECTOR NAME	ADDRESS				25a. DATE REC'D. BY REGISTRAR				25b. REGISTRAR'S SIGNATURE	
F. Gasch's Sons F.H. P.A. Hyattsville, Md.					APR 11 1986				<i>John W. Harlan, Jr.</i>	

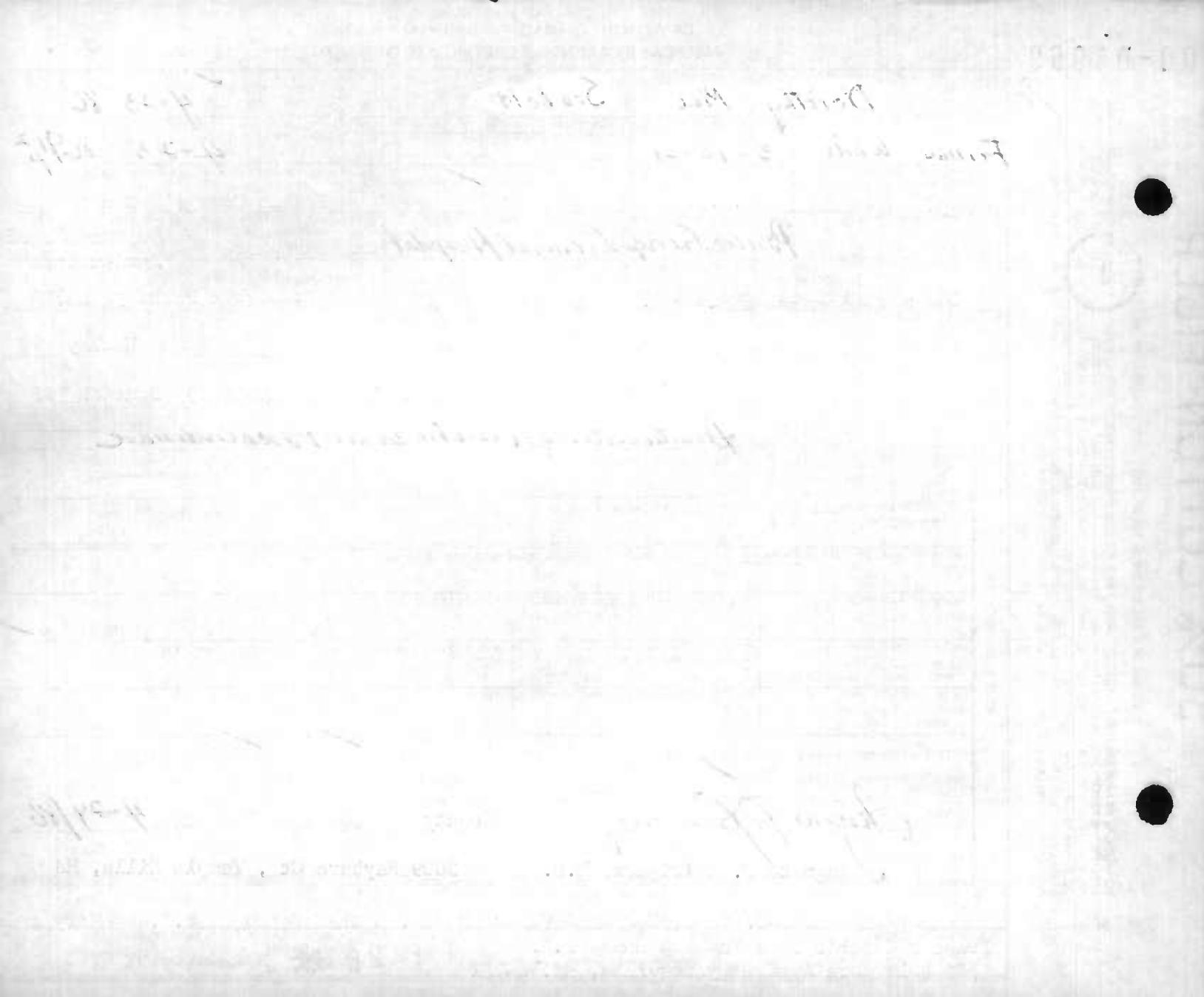
annual average influence vegetation infiltration coefficient

of vegetation / 1.0.7 and above

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 1. RETAIN FORM 1 AND 2 FOR 2 MONTHS. PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO. 1 2 3 0 4
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE KNOWN OF ESTI- MATED	MONTH	DAY	YEAR	7b. HOUR		
DOROTHY			MAE	SEABOLT	<input checked="" type="checkbox"/>	4-23	1986					
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	7. IF UNDER 1 YR. MONTHS DAYS	8. IF UNDER 24 HRS. HOURS MIN.	9c. DATE PRONOUNCED DEAD	MONTH	DAY	YEAR	2d. HOUR		
FEMALE	WHITE	3 - 16 - 21	65 yrs			4-23	1986	9	BALTIMORE CITY OR COUNTY OF DEATH			
10a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?			8	MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	Prince George's County MD.					
Pennsylvania		U.S.A.										
11. CITY OR TOWN OF DEATH			11a. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY			
Cheverly			Prince George's Hospital			Stenographer			Department of Agriculture			
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS		13f. ADDRESS			
Maryland		Prince George's		Hyattsville,		YES <input checked="" type="checkbox"/>	7100 Greenvale Parkway		20784			
14. FATHER'S NAME FIRST			MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST			MIDDLE	LAST	Hockey		
Jesse			James	Marshall	Mary							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS			
No			577-20-4196			Edgar N. Seabolt (Husband)			Same as #13			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Hedonic arteriosclerotic cardiovascular disease</i> DUE TO, OR AS A CONSEQUENCE OF												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last. (b) <i></i> DUE TO, OR AS A CONSEQUENCE OF (c) <i></i>												
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).												
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY?						
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART 1 OR PART 2)			YES <input type="checkbox"/> NO <input type="checkbox"/>			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN	COUNTY	STATE	
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>												
ACTUAL SIGNATURE <i>Augusto P. Rodriguez</i>			TITLE (SPECIFY) M.D. Deputy			MEDICAL EXAMINER			DATE SIGNED <i>4-24-86</i>			
EXAMINER'S NAME (TYPE OR PRINT)			ADDRESS 5009 Rayburn Ct., Temple Hills, Md.									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE Burial 4/28/86			23c. NAME OF CEMETERY OR CREMATORIAL Maryland Veterans Cem.			23d. LOCATION CITY OR TOWN Cheltenham			
24. FUNERAL DIRECTOR Francis Gasch's Sons Funeral Home, P.A. 4739 Baltimore Avenue Hyattsville, Md. 20781									COUNTY P.G. STATE Maryland			
									25a. DATE REC'D. BY REGISTRAR APR 28 1986			
									25b. REGISTRAR'S SIGNATURE <i>Jeanne Dawson</i>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO. 2364	
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR				
HENRY CLAYTON SEBRING						April 13, 1986			2:43a m				
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.	
Male		White		Feb. 28, 1918			68			YRS.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.			
Washington		U.S.A.					Prince George's County						
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY						
Lanham		AMI/Doctors' Hosp. of Pr. Geo. Co.		Printing			ARA Services						
13a. STATE		13b. COUNTY		13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS		20715		
Md.		P.G.		Mt. Ranier			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		3714 35th Street				
14. FATHER'S NAME FIRST		MIDDLE		LAST			15. MOTHER'S MAIDEN NAME FIRST		MIDDLE		LAST		
Unknown							Zell				Logan		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No		16b. SOCIAL SECURITY NO.		17. INFORMANT			ADDRESS			3714 35th Street			
		382- 16-5320		Allen Sebring			Mt. Ranier, Md. 20711						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory Failure.												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause last. (b) Pneumonia / Renal Failure / congestive heart failure													
DUE TO, OR AS A CONSEQUENCE OF (c) Acquired Immune Deficiency Syndrome													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?						
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET			CITY OR TOWN			COUNTY			STATE
22a. I certify that (I) (this hospital) attended the deceased from 4/12/86 to 4/12/86, that (I) (we) last saw the deceased alive on 4/12/86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE				DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED			4/14/86
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS			14300 Gaithersburg Fun. Home						
GERARD CHAM PALOUX													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN			23e. COUNTY			STATE
Burial		4/16/86		Ft. Lincoln			Brentwood			P.G.			Md.
24. FUNERAL DIRECTOR NAME		Rendon/Hale Lanham Fun'l. Home 9013 Annapolis Rd. Lanham, Md. 20706					25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE			
							APR 18 1986						

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Facultad de
Arquitectura
y Urbanismo
Universidad de Buenos Aires

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner may be bound or one.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH							
				8	6	1	2 3 6 5
				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT)		FIRST CHARLES	MIDDLE NORMAN	LAST SHAW		2a DATE OF DEATH 04-30-86	MONTH DAY YEAR
3. SEX Male		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR July 12, 1950		6. AGE (IN YEARS LAST BIRTHDAY) 35	IF UNDER 1 YEAR MONTHS DAYS YRS
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington, D.C. USA		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGE'S COUNTY MD.	
10. CITY OR TOWN OF DEATH CHEVERLY		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) PRINCE GEORGE'S GENERAL HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Control Data		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Maryland		13b. COUNTY PG		13c. CITY OR TOWN Forestville		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST Charles M. Shaw		LAST		15. MOTHER'S MAIDEN NAME FIRST Frances Griffin		MIDDLE LAST	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) no 578 66 7405		17. INFORMANT Frances Shaw-mother-4307 Shell St		ADDRESS	
18. CAUSE OF DEATH (Enter only one cause per line for 18, 1b, and 1c.) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>MULTIORGAN FAILURE</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>ACUTE HEMORRHAGIC PANCREATITIS</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>SEPSIS / ACIDOSIS</u>							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a <u>RENAL FAILURE / COAGULOPATHY</u>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> (IF CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER))		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN	COUNTY STATE
22a. I certify that (I) (this hospital) attended the deceased from <u>4/27/86</u> to <u>4/30/86</u> , that (I) (we) last saw the deceased alive on <u>4/30/86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>Rakesh Sahn</u>		DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 5/2/86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Rakesh Sahn</u>		22e. ADDRESS <u>P-G-HOSPITAL, CHEVERLY, MD</u>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE May 6, 1986		23c. NAME OF CEMETERY OR CREMATORIAL Harmony Memorial Park		23d. LOCATION Landover, Maryland	
24. FUNERAL DIRECTOR NAME Stewart				25a. DATE REC'D. BY REGISTRAR MAY 6 1986		25b. REGISTRAR'S SIGNATURE <u>Jodie Davidson-Pender</u>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in full by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Please send it back to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH													
1 - FOR STATE REGISTRAR				3 0 1 2 3 6 6 REG. NO.									
1a DECEASED NAME (TYPE OR PRINT)		FIRST	MIDDLE	LAST	2a DATE OF DEATH		MONTH	DAY	YEAR	2b HOUR			
		James	Richard	Sherman, Sr.	April 29, 1986					1:05A M			
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR MONTHS DAYS		8. IF UNDER 24 HRS HOURS MIN.			
Male		Caucasian		Aug. 14 1910		75							
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH		10. CITY OR TOWN OF DEATH					
Virginia		USA				Prince George's		Laurel					
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12. INDIVIDUAL OCCUPATION RETIRED				12b. KIND OF BUSINESS OR INDUSTRY					
Greater Laurel Beltsville Hospital								Mach. Operator Thompson Steel					
13a. STATE Md.		13b. COUNTY P.G.		13c. CITY OR TOWN Laurel		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 7603 Laurel Ridge Ct. 26707		14. FATHER'S NAME			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 217-07-7343		17. INFORMANT Edith Sherman		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>RESPIRATORY Failure</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Pneumonia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) DUE TO, OR AS A CONSEQUENCE OF		15. MOTHER'S MAIDEN NAME Minnie		16. MIDDLE Alice		17. LAST McDonald	
18. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1wk													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) 1/21 19 86		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE			
22a. I certify that (I) (this hospital) attended the deceased from 4/20 19 86 to 4/29 19 86, that (I) (we) lost saw the deceased alive on above, (I) (we) (did) did not view the body after death.													
22b. SIGNATURE <u>Dr. John MD</u>		22c. DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22d. DATE SIGNED 4/29/86							
22e. PHYSICIAN'S NAME (TYPE OR PRINT) Gregory A Compton		23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 4/30/86		23c. NAME OF CEMETERY OR CREMATORIAL Balto. Wash. Crematory		23d. LOCATION CITY OR TOWN Laurel		23e. COUNTY Md.			
24. FUNERAL DIRECTOR NAME FLECK F.H. INC.		25a. ADDRESS 1601 Sandy Spring Rd Laurel, MD 20707		25b. DATE REC'D. BY REGISTRAR APR 30 1986		25c. REGISTRAR'S SIGNATURE <u>J. K. Kline, Jr.</u>							

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 2 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR.

PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM BM 3, RIBBON PAGE 5 FOR YOUR FILES.

TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE TORN OUT, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET,

BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 12361

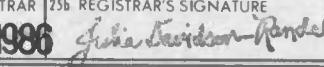
1- FOR STATE REGISTRAR		2. DATE KNOWN OF ESTI- MATED <input checked="" type="checkbox"/> MONTH DAY YEAR 4/23 1986										2b. HOUR MONTH DAY YEAR 3:45						
1. DECEASED NAME (TYPE OR PRINT)		FIRST Loren			MIDDLE Joseph			LAST Show			2c. DATE PRONOUNCED DEAD 4/23 1986							
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Nov. 26, 1916			6. AGE (IN YEARS LAST BIRTHDAY) 69 yrs.		7. IF UNDER 1 YR. MONTHS DAYS		8. IF UNDER 24 HRS. HOURS MIN.		9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's County MD.					
7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Penn.		7b. CITIZEN OF WHAT COUNTRY? U. S. A.			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			10. CITY OR TOWN OF DEATH Hyattsville		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 1918 Lebanon Street			12a. USUAL OCCUPATION (TYPE OF WORK) FOR MOST OF WORKING LIFE) U. S. Navy (Retired.)		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE Maryland		13b. COUNTY Prince George's		13c. CITY OR TOWN Hyattsville			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 1918 Lebanon Street 20783									
14. FATHER'S NAME FIRST		MIDDLE			LAST Show			15. MOTHER'S MAIDEN NAME FIRST		MIDDLE			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES) Yes Navy.		16b. SOCIAL SECURITY NO. 198-18-0675		17. INFORMANT ADDRESS 24509 Hanson Rd. Gaithersburg Loren D. Show (Nephew)	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Acute myocardial disease												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.		DUE TO, OR AS A CONSEQUENCE OF																
		(b) generalized arteriosclerosis. DUE TO, OR AS A CONSEQUENCE OF																
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).																		
None																		
19a. DATE OF OPERATION None		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?												20 AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART 1 OR PART 2)			21d. LOCATION STREET		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION CITY OR TOWN		21g. COUNTY		21h. STATE		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>																		
22a. I certify that I took charge of the remains described above, held an death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion																
ACTUAL SIGNATURE <i>John S. Rogers</i>		TITLE (SPECIFY) Deputy M.D. MEDICAL EXAMINER 1919 Seminary Road Silver Spring, Montgomery County, Md.												DATE SIGNED 4/24/86				
EXAMINER'S NAME (TYPE OR PRINT) John S. Rogers, M.D.		ADDRESS																
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial.		23b. DATE Apr. 28, 1986		23c. NAME OF CEMETERY OR CREMATORIAL Takoma Funeral Home.			23d. LOCATION CITY OR TOWN Arlington			23e. COUNTY		23f. STATE Va.						
24. FUNERAL DIRECTOR Name Address <i>Arthur Kellersh</i>		25a. DATE REC'D. BY REGISTRAR APR 28 1986		25b. REGISTRAR'S SIGNATURE <i>Julia Davidson</i>														
25m. DHMH - 17 (VR A15 ME (5))																		

26810-00



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PEN IN ITEM 18, ALONG WITH FORM P.M. RETAIN PAGE 3 FOR YOUR FILES.

TO FUNERAL DIRECTOR: PAGE 4 SHOULD BE FORWARDED TO THE CHIEF, NEEDED FOR A CEMETERY OR Cremation PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND 21201, PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO. 2358			
1 - STATE REGISTRAR			1 DECEASED NAME FIRST			MIDDLE			LAST			2a. DATE KNOWN OF ESTI- DEATH MATED		2b. HOUR	
			Jerome						Simpson			<input checked="" type="checkbox"/> 4/24		1986 M	
3 SEX		4. RACE		5 DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YR.		IF UNDER 24 HRS. MONTHS DAYS HOURS MIN		2c. DATE PRONOUNCED DEAD		2d. HOUR	
Male		Black		May 2, 1934		51 yrs.						4/24 1986		24 HOUR 7:55 M	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8		MARRIED <input checked="" type="checkbox"/> NEVER MARRIED		WIDOWED <input type="checkbox"/>		DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH		MD.	
Wash., DC.		USA										Prince George's County			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY						
Palmer Park			7922 Allendale Drive			Electrician Supervisor						20785			
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)															
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS							
Maryland		Prince George's		Palmer Park		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		7922 Allendale Drive							
14. FATHER'S NAME FIRST			MIDDLE			15. MOTHER'S MAIDEN NAME FIRST			LAST						
Matthew			Kendall			Nannie Lee Simpson									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS						
yes			579 48 0674			Verleece Simpson-wife-7922 Allendale									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>Acute myocardial disease</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) <u>chronic myocardial disease.</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a). None															
19a. DATE OF OPERATION None			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) None									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY	STATE		
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>															
ACTUAL SIGNATURE 		EXAMINER'S NAME (TYPE OR PRINT)			TITLE (SPECIFY) Deputy M.D.			MEDICAL EXAMINER			DATE SIGNED 4/25/86				
John S. Rogers, M.D.			1919 Seminary Road			Silver Spring, Montgomery County, Md.									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE May 1, 1986			23c. NAME OF CEMETERY OR CREMATORIAL Cheltenham Veterans Cemetery			23d. LOCATION CITY OR TOWN Cheltenham, Md.						
24. FUNERAL DIRECTOR NAME John Stewart									25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE 			
Stewart Funeral Home-4001 Benning Road, N.W.			MAY 6 1986												
BP _____															
DHMH - 17 (VR A15 ME (5))															

10838-3

REGISTRATION NO.



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3, RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS, AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO. 2369											
1- FOR STATE REGISTRAR			1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE KNOWN OF ESTI- DEATH MATED			2b. TIME P.M. 1:20											
Fred						Smith			<input checked="" type="checkbox"/> 4/3 1986														
3. SEX		4 RACE	5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN		2c. DATE PRONOUNCED DEAD			2d. TIME P.M. 1:20									
Male		Black	Mar. 23, 1923		63 yrs.						4/3 1986												
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED WIDOWED		NEVER MARRIED DIVORCED		9. BALTIMORE CITY OR COUNTY OF DEATH			MD.												
N.C.		USA		<input checked="" type="checkbox"/>		<input type="checkbox"/>		Prince George's County															
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY											
Mt. Rainier			3212 Otis Street						Disable Veteran			Unknown											
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS			20822												
Maryland		Prince George's		Mt. Rainier				3212 Otis Street															
14. FATHER'S NAME FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES)												16b. SOCIAL SECURITY NO.			17. INFORMANT		
Leroy Smith			Katie Lawrence			Yes												245-20-3288			Mrs. Jocile M. West/daughter/same as 13e		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute myocardial disease</u>															APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH								
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last.																							
{ (b) <u>chronic myocardial disease.</u> DUE TO, OR AS A CONSEQUENCE OF																							
(c)																							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).																							
None			None																				
19a. DATE OF OPERATION None			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?												20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			None														
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY			STATE								
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																							
ACTUAL SIGNATURE <i>John S. Rogers, M.D.</i>															TITLE (SPECIFY) Deputy MEDICAL EXAMINER 1919 Seminary Road Silver Spring, Montgomery County, Md.								
EXAMINER'S NAME (TYPE OR PRINT)			ADDRESS												DATE SIGNED 4/4/86								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE Burial 4-9-86			23c. NAME OF CEMETERY OR CREMATORIAL Harmony Memorial			23d. LOCATION CITY OR TOWN Landover, Md.			23e. DATE REC'D. BY REGISTRAR APR 08 1986											
24. FUNERAL DIRECTOR John T. Rhines Co., 3015 12th St. N.E. D.C. 20017															23f. REGISTRAR'S SIGNATURE <i>Julie Davidson-Pindell</i>								
DHMH - 17 (VR A15 ME (5))																							

AC 080-00



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the deceased be reponed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other disposition.

IMPORTANT: If item 18 shows any injury, or other traumatic event, the medical examiner may be notified of one.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												
86 12370 REG. NO.												
1 - STATE REGISTRAR			2a DATE OF DEATH MONTH DAY YEAR									
I. DECEASED NAME FIRST MIDDLE LAST			2b HOUR									
JOHN R. Smith JR			04 11 86 10:47 AM									
3. SEX Male			4 RACE White			5 DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			
Male			White			July 31, 1937			48 YRS			
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington DC			7b CITIZEN OF WHAT COUNTRY? USA			8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGES MD.			
10 CITY OR TOWN OF DEATH CLINTON			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN BUCH FACILITY, GIVE STREET ADDRESS) Southern Md Hospital			12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Grounds Keeper			12b KIND OF BUSINESS OR INDUSTRY cedar Hill Cemetery			
13a STATE Maryland			13b COUNTY Pr Geo			13c CITY OR TOWN Camp Spgs			13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			
14 FATHER'S NAME FIRST MIDDLE LAST			John R. Smith Sr			15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST						
John			R. Smith Sr			Bertha Viola Jenkins						
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17 INFORMANT			ADDRESS			
No			577-50-0465			Jean Smith			Same as #13			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO, OR AS A CONSEQUENCE OF Extensive Myocardial infarction Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) DUE TO, OR AS A CONSEQUENCE OF CTE, pul-Ede my Hsp, ddy												
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH												
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)												
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED						20a AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
									YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M.			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from April 6th 86 to April 11th 86, that (I) (we) last saw the deceased alive on April 11th 86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			MS						4-11-86			
ABULHASAN U ANSARI						22e. ADDRESS 8926 Woodyard Road #101 Clinton MD. 20735						
23a BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN COUNTY STATE			
Burial			14Apr1986			Cedar Hill Cemetery Suitland PG Md						
24. FUNERAL DIRECTOR NAME			ADDRESS			25a. DATE REC'D. BY REGISTRAR IN REGISTRAR'S SIGNATURE						
Robert E Wilhelm Funeral Home			Suitland, Md.			APR 15 1986						

30380-0

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the Burial-Transit Permit. Then please remove carbon copies. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					REG. NO. 8 6 1 2 3 7 1
1. DECEASED NAME FIRST MIDDLE LAST			2a. DATE OF DEATH MONTH DAY YEAR		2b. HOUR
Mary L. Smith			4 30 1986		1:35 PM
3. SEX FEMALE	4. RACE CAUC.	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY) 73 YRS		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE COUNTRY Maryland	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Prince George MD.		
10. CITY OR TOWN OF DEATH Forestville	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Regency Nursing Home			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife	
13a. STATE Maryland	13b. COUNTY Pr. George	13c. CITY OR TOWN Upper Marlboro	13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 10712 Brookwood Ave. 20772	
14. FATHER'S NAME FIRST MIDDLE LAST	15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST				
Joseph	Pilkerten	Grace	Lambert		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no	16b. SOCIAL SECURITY NO. 577-20-8648	17. INFORMANT Robert Smith same as item 13	ADDRESS		
18. CAUSE OF DEATH (Enter only one cause per line for 1a, (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) a SHD DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) DUE TO, OR AS A CONSEQUENCE OF (c)					
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET	CITY OR TOWN	COUNTY	STATE
22a. I certify that (I) (This hospital) attended the deceased from 8/11/1982 to 4/30/1986 , that (I) (was) lost saw the deceased alive on 4/20/1986 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (was) (did not) view the body after death.					
22b. SIGNATURE <i>William Kent Furst MD</i>			DEGREE	22c. DATE SIGNED 4/30/86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) William Kent Furst, M.D.	22e. ADDRESS 11701 Livingston Rd. Ft. Wash. Md.				
23a. BURIAL, CREMATION, REMOVAL (TYPE OR PRINT) Burial	23b. DATE 5/3/86	23c. NAME OF CEMETERY OR CREMATORIAL Resurrection Cemetery	23d. LOCATION STREET Clinton	COUNTY P.G.	STATE Md.
24. FUNERAL DIRECTOR NAME G.P. Kalas F.H. 6160 Oxon Hill Rd. Oxon Hill, Md.	ADDRESS 20745	25a. DATE REC'D. BY REGISTRAR MAY 5 1986		25b. REGISTRAR'S SIGNATURE <i>Julia K. Kildare</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Please sign it.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it may be filed in the funeral director's office or with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 18 is marked or if item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO.			
1. FOR STATE REGISTRAR			MIDDLE			LAST			2d DATE OF DEATH		MONTH	DAY	YEAR	2b HOUR	
1. DECEASED NAME (TYPE OR PRINT)			MILDRED			E SPAIN			APRIL 14, 1986				6:45 pm		
1. SEX			4 RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.		
FEMALE			CAUCASIAN			MONTH DAY YEAR			57 YRS						
7. BIRTHPLACE COUNTRY			7b CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH		MD.				
NORTH CAROLINA			USA						PRINCE GEORGES MARYLAND		DEPT. OF HEALTH HUMAN SERVICES				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY				
HYATTSVILLE			3105 ROSEMARY LANE						SECRETARY						
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13e. STREET ADDRESS / ZIP CODE						
MARYLAND			PRINCE GEO.			HYATTSVILLE			3105 ROSEMARY LANE 20783						
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME			16. SOCIAL SECURITY NO.			17. INFORMANT		ADDRESS				
THEODORE			AMY			240-36-9965			JOHN P. SPAIN		HUSBAND SAME AS 13				
18a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			18b. SOCIAL SECURITY NO.			18c. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			18d. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)						
NO									RESPIRATORY DEPRESSION		IMMEDIATE				
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last			(b)			DUE TO, OR AS A CONSEQUENCE OF WIDE SPREAD METASTASES			4 MO						
			(c)			DUE TO, OR AS A CONSEQUENCE OF CARCINOMA BREAST			4 yrs						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1.															
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY		STATE		
22a. I certify that (I) (this hospital) attended the deceased from 4/13/86 to 4/14/86, that (I) (we) last saw the deceased alive on 4/10/86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.															
22b. SIGNATURE <i>Richard P. Delaney, M.D.</i>															
22c. DEGREE															
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>															
22e. ADDRESS			22f. DATE SIGNED 4/15/86												
Richard P. Delaney, M.D.			4323 Havard Street, Silver Spring, Md. 20906												
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CHURCH			23d. LOCATION						
BURIAL			APR. 19, 1986			COKESBURY U. METHODIST CHURCH CEMETERY			HENDERSON						
24. FUNERAL DIRECTOR NAME			25a. DATE REC'D. BY REGISTRAR			25b. SIGNATURE									
FRANCIS J. COLLINS, JR.			APR 21 1986			<i>J. Francis J. Collins, Jr.</i>									
500 UNIVERSITY BLVD. WEST SILVER SPRING, MD.															

224

20% CROWN
20% DRY
20% WET
20% DRY
20% WET



20% WET

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, sign the funeral director, page 3 should be detached for use on the burial permit. Then please remove carbon paper. Page 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as Item 18 shows any injury, or other traumatic event, the medical examiner will be called.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 3 5 1 2 3 / 3			
1. DECEASED NAME Margaret P. Standish				2a. DATE OF DEATH April 16, 1986				2b. HOUR 10:30 P.M.					
1-SEX Female		4. RACE White		5. DATE OF BIRTH February 29, 1912		6. AGE (IN YEARS LAST BIRTHDAY) 74 yrs		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH PG		MD.					
10. CITY OR TOWN OF DEATH Riverdale		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Leland Memorial Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Own Home							
13a. STATE Maryland		13b. COUNTY P.G.		13c. CITY OR TOWN Hyattsville		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 5802 Maryhurst Drive 20781					
14. FATHER'S NAME FIRST Matthew		MIDDLE Buday		LAST Buday		15. MOTHER'S MAIDEN NAME FIRST Maria		MIDDLE Ganoczy		LAST			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 196-26-1401		17. INFORMANT Mr. George Standish, Jr. Beltsville, Md. 20705		ADDRESS 4214 Wicomico Ave.							
18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRAL INFARCT DUE TO, OR AS A CONSEQUENCE OF (b) HYPERTENSION Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first.												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 14 days	
DUE TO, OR AS A CONSEQUENCE OF (c) CORONARY ARTERY DISEASE													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)													
19a. DATE OF OPERATION n/a		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE			
22a. I certify that (I) (this hospital) attended the deceased from 4. 2. 1986 to 4. 16. 1986 , that (I) (was) lost saw the deceased alive on 4-16-1986 , and that in (my) (was) opinion death occurred on the date and hour and from the causes stated above, (I) (was) (did not) view the body after death.													
22b. SIGNATURE K. Matthew		DEGREE M.D.		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 4/17/86							
22d. PHYSICIAN'S NAME (TYPE OR PRINT) K. Matthew		22e. ADDRESS 6510 Kenilworth Ave Riverdale MD 20737											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Apr. 19, 1986		23c. NAME OF CEMETERY OR CREMATORIAL St. Mary's Russian Orthodox Cemetery		23d. LOCATION CITY OR TOWN Masontown		COUNTY Fayette		STATE Pa.			
24. FUNERAL DIRECTOR NAME F. Gasch's Sons F.H. P.A. Hyattsville, Maryland		25a. DATE REC'D. BY REGISTRAR APR 21 1986 John Anderson - Rendell				25b. REGISTRAR'S SIGNATURE							
DHMH - 16 60M 7/B4 (VRA 15, 4)													

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be informed by the hospital or attending physician.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH													
REG. NO. 8912374													
1 - FOR STATE REGISTRAR			1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR 3:10 P.M.	
ALGER			E.			STONEBURNER			4/11/86				
3. SEX MALE			4. RACE CAUC.			5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY) 70 YRS			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) U.S.A. VIRGINIA			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGE'S COUNTY MD				
10. CITY OR TOWN OF DEATH CLINTON			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SOUTHERN MARYLAND HOSPITAL CENTER			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) TRUCKDRIVER			12b. KIND OF BUSINESS OR INDUSTRY SAFeway				
13a. STATE MARYLAND			13b. COUNTY PRINCE GEORGE'S COKEEK			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE 20607	
14. FATHER'S NAME FIRST SAMUEL			MIDDLE STONEBURNER			LAST EFFIE			15. MOTHER'S MAIDEN NAME FIRST ALGER E. STONEBURNER			ADDRESS 7300 DONNELL PL. #C2 FORESTVILLE MARYLAND	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) UNKNOWN			17. INFORMANT 227-18-4193			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) respiratory failure - sepsis DUE TO, OR AS A CONSEQUENCE OF (b) hypertend Autic Anoxym . Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) DUE TO, OR AS A CONSEQUENCE OF			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) myocardial infarction - fungal infection													
19a. DATE OF OPERATION 3/14/86			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Hypertend Autic Anoxym			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) hypertend Autic Anoxym			22a. DATE SIGNED 20/3/86				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from _____ to _____, that (I) (we) last saw the deceased alive on _____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE <i>G. Grover, M.D.</i>			22c. DEGREE M.D.			22d. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22e. DATE SIGNED 20/3/86				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) G. GROVER, M.D.			22e. ADDRESS 7501 SURRETT'S ROAD, CLINTON MD										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE APRIL 14, 1986			23c. NAME OF CEMETERY OR CREMATORIAL UNION FORGE CEMETERY			23d. LOCATION CITY OR TOWN WOODSTOCK			STATE VIRGINIA	
24. FUNERAL DIRECTOR NAME LEE FUNERAL HOME, INC.			25a. DATE REC'D. BY REGISTRAR APR 17 1986			25b. REGISTRAR'S SIGNATURE <i>Jeanne Landon Pendleton</i>							
6613 OLD ALEXANDER FERRY ROAD CLINTON, MARYLAND 20735													

10000-0

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. WRITE THE WORD "PENDING" IN PENCIL IN ITEM 1B. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE KEPT WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO. 2375		
1- STATE REGISTRAR			2a. DATE KNOWN <input type="checkbox"/> MONTH DAY YEAR OF ESTI- DEATH MATED <input checked="" type="checkbox"/> APR 18 1986									2b. HOUR		
I. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE			LAST						M		
RAY JACKSON						SUIT								
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN		7c. DATE PRONOUNCED DEAD		
Male		White		March 8, 1899		87 yrs.						APR 18 1986		
7d. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7e. CITIZEN OF WHAT COUNTRY?		7f. ADDRESS		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED		9. BALTIMORE CITY OR COUNTY OF DEATH		2d. HOUR				
Maryland		U. S. A.						Prince George's		6:10 a.m.				
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY								
Upper Marlboro		17411 Central Avenue		Tobacco Farmer		Own Farm								
13a. STATE MARYLAND		13b. COUNTY Pr. Geo's		13c. CITY OR TOWN Upper Marlboro		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 17411 Central Ave/ 20772		MD.				
14. FATHER'S NAME Jackson		MIDDLE Ritchie		LAST Suit		15. MOTHER'S MAIDEN NAME Mary		Elizabeth Harvey						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No		16b. SOCIAL SECURITY NO. -----		16c. ADDRESS 579-28-3226		17. INFORMANT Mr. Lawrence F. Suit-Upper Marlboro, Md.		20772						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cerebro-cardiovascular disease DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the <u>under-</u> lying cause lost. (b) DUE TO, OR AS A CONSEQUENCE OF (c)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).														
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?									20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY STATE		
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>														
ACTUAL SIGNATURE EXAMINER'S NAME (TYPE OR PRINT)		M.D. Deputy MEDICAL EXAMINER Augusto P. Rodriguez, M.D. 5009 Rayburn CT, Temple Hills, MD 20748										DATE SIGNED 4/18/1986		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE Burial 4/21/86			23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS			23d. LOCATION CITY OR TOWN Clinton (Pr. Geo's) Md.			COUNTY STATE		
24. FUNERAL DIRECTOR Richard A. Coleman -Upper Marlboro, Md. 20772									25a. DATE REC'D. BY REGISTRAR APR 28 1986			25b. REGISTRAR'S SIGNATURE Julia L. Rodden-Rendell		
DHMH - 17 (VR A15 ME (5))														

20% cotton 80% poly

K1840-0

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2 AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM. RETAIN PAGE 5 FOR YOUR FILES.

TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS, AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO. 1 2 3 7 6	
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE KNOWN OF ESTI- DEATH MATED				MONTH	DAY	YEAR	2b. HOUR
BRUCE TANKSLEY						<input checked="" type="checkbox"/> 4-12-86 19							
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR 5 24 64	6. AGE (IN YEARS) (LAST BIRTHDAY) 21 YRS.	7. IF UNDER 1 YR. MONTHS DAYS	8. IF UNDER 24 HRS. HOURS MIN	2c. DATE PRONOUNCED DEAD				MONTH	DAY	YEAR	2d HOUR
M	B					<input checked="" type="checkbox"/> 4-12-86 19							5:15a
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	9. BALTIMORE CITY OR COUNTY OF DEATH				PRINCE GEORGE'S COUNTY MD.			
NEW JERSEY		U.S.A.			<input checked="" type="checkbox"/>	999999							
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY				
PRINCE GEORGE		Northbound BW Pkwy. just S. of RT 197			N/A								
13a. STATE NEW JERSEY		13b. COUNTY		13c. CITY OR TOWN NEWARK	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS 510 S. 15th STREET							
14. FATHER'S NAME CLYDE		MIDDLE	LAST	15. MOTHER'S MAIDEN NAME JANICE				LAST BLAKE					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO. NO Yes 149-64-1286			17. INFORMANT JANICE TANKSLEY				ADDRESS NEWARK N.J.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cranio-cerebral trauma DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the <u>under-</u> lying cause lost. (b) DUE TO, OR AS A CONSEQUENCE OF (c)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I. 19a. DATE OF OPERATION												19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY ? HOUR A.M. MONTH DAY YEAR P.M. 4-12-86 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) passenger in an auto/fixed object impact				20. AUTOPSY? (HEAD ONLY) YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) hwy.			21f. LOCATION STREET Northbd. BW Pkwy. just S. of RT 197				CITY OR TOWN County State Prince George's Maryland				
22a. I certify that I took charge of the remains described above. (HEAD ONLY) death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Margarita A. Korell, M.D.												TITLE (SPECIFY) M.D. Assistant MEDICAL EXAMINER	
EXAMINER'S NAME (TYPE OR PRINT)		Margarita A. Korell, M.D.			ADDRESS 111 Penn Street				DATE SIGNED 4-12-86				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 4-17-86		23c. NAME OF CEMETERY OR CREMATORIAL EVERGREEN			23d. LOCATION CITY OR TOWN HILLSIDE				COUNTY N.J.		
24. FUNERAL DIRECTOR NAME WM.C. MARCH F/H INC.		ADDRESS 1101 E. NORTH AVE.			25a. DATE REC'D. BY REGISTRAR APR 14 1986				25b. REGISTRAR'S SIGNATURE June Sanderson				

9785 | 008

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner should be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO. 89 2377				
1. FOR STATE REGISTRAR			1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR				
			HOWARD PERRY TAYLOR						APRIL 9 1986			4:15P M				
3. SEX Male			4. RACE Black			5. DATE OF BIRTH MONTH DAY YEAR March 8, 1948			6. AGE (IN YEARS LAST BIRTHDAY) 38 YRS			IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.		
7a. BIRTHPLACE COUNTRY Virginia			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's County MD.							
10. CITY OR TOWN OF DEATH Lanham			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Doctors' Hospital of Pr. Geo. Co.			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired/Military/US Army			12b. KIND OF BUSINESS OR INDUSTRY							
13a. STATE Maryland			13b. COUNTY P.G.			13c. CITY OR TOWN Lanham			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			14. FATHER'S NAME FIRST MIDDLE LAST Eucless Taylor			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Alma B Walker	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes/Army			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 1967/1985			17. INFORMANT ADDRESS 9963 Goodluck Road, Lanham, Ethel Rebecca Bush Taylor (wife) Md.										
18. CAUSE OF DEATH (Enter only one cause per line for item 18a and c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>underlying factor</i>													APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>menomen</i> (c) <i>overexposure to sun</i>																
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1b: <i>overexposure to sun</i>																
19a. MEDICAL CERTIFICATION			19b. DATE OF OPERATION			19c. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
									YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			22a. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NO WHILE <input type="checkbox"/>			22b. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) 22c. LOCATION STREET CITY OR TOWNSHIP COUNTY STATE 86 4/4 19 86 4/9 19 86				
22a. I certify that (if this hospital) attended the deceased from <u>19 86</u> to <u>19 86</u> , that (if we) last saw the deceased alive on <u>19 86</u> and that (if my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we) (did) did not view the body after death.			22d. SIGNATURE <i>Lewis H. Dennis</i>			22e. DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22f. DATE SIGNED 4/9/86							
22g. PHYSICIAN'S NAME (TYPE OR PRINT) Lewis H. Dennis, M.D.			22h. ADDRESS Silver Springs, Maryland 20903 831 University Blvd. East													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 04/13/86			23c. NAME OF CEMETERY OR CREMATORIAL Oakland Cemetery			23d. LOCATION CITY OR TOWNSHIP COUNTY STATE Suffolk, Virginia							
24. FUNERAL DIRECTOR NAME LATNEY's Funeral Home 3831 Georgia Ave. NW; Washington, DC 20011			25a. DATE REC'D. BY REGISTRAR APR 22 1986			25b. REGISTRAR'S SIGNATURE <i>Johanna Davidson Henderson</i>										

31890



00-04247

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed, it may be detached for use as the burial-trust permit. Then present this certificate to the State Dept. of Health and Mental Hygiene prior to burial or cremation. If item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

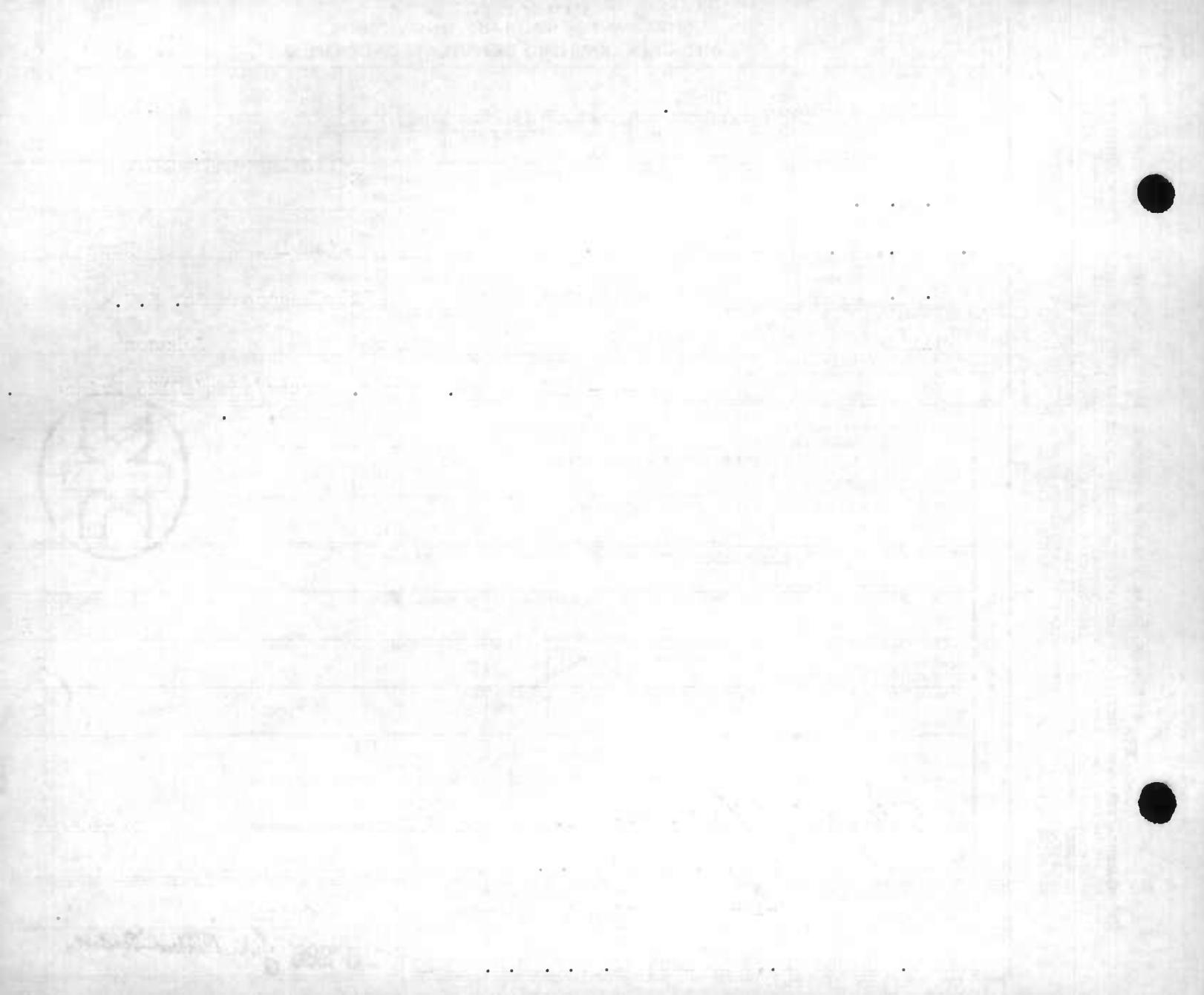
STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH														
1. DECEASED NAME (TYPE OR PRINT)				FIRST	MIDDLE	LAST	2d. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR			
WILLIAM A. TAYLOR							04-16-86				9:48AM			
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS			
Male		Black		June 29, 1956			29		YRS.		MONTHS DAYS HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGE'S COUNTY						
Wash., D. C.		U. S. A.												
10. CITY OR TOWN OF DEATH CHEVERLY		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) PRINCE GEORGE'S GENERAL HOSPITAL						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY				
Md.		P. G.			Capitol Heights			Maintenance		Cleaning Co.				
13a. STATE Md.		13b. COUNTY P. G.		13c. CITY OR TOWN Capitol Heights		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 1609 Eastern Ave. 20743						
14. FATHER'S NAME FIRST Macon		MIDDLE C.	LAST Taylor	15. MOTHER'S MAIDEN NAME FIRST Leonora			MIDDLE G.	LAST Davis						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		16c. INFORMANT			ADDRESS							
No		577-78-5955		Leonora G. Taylor-Mother-1609 Eastern Ave.										
18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIOPULMONARY ARREST														
DUE TO, OR AS A CONSEQUENCE OF (b) INCREASED INTRACRANIAL TENSION DUE TO														
DUE TO, OR AS A CONSEQUENCE OF MULTIPLE MENINGIOMAS														
(c)														
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a INFECTION OF UNKNOWN SOURCE														
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
					YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		HRS (HOURS)							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b PART I OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY		STATE		
22a. I certify that (I) (this hospital) attended the deceased from APRIL 12, 1986, to APRIL 16, 1986, that (I) (we) last saw the deceased alive on APRIL 15, 1986, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.														
22b. SIGNATURE Pritam S. Saini		22c. DEGREE MD			22d. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL STAFF <input type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/>			DATE SIGNED 4-16-86						
22e. PHYSICIAN'S NAME (TYPE OR PRINT) PRITAM S. SAINI		22f. ADDRESS P. G. G. H. AND MED CTR CHEVERLY MD 20785												
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 4-21-86		23c. NAME OF CEMETERY OR CREMATORIAL Harmony Memo. Park			23d. LOCATION Landover		CITY OR TOWN		COUNTY		STATE	
24. FUNERAL DIRECTOR T. C. Pinckney NAME Spangler Funeral Home		ADDRESS 524 - 8th St., N. A.			25a. DATE REC'D. BY REGISTRAR APR 22 1986			25b. REGISTRAR'S SIGNATURE Julie Davidson-Arthur						

100-10-0



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. RETAIN PAGE 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3, RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 3 AND 2 SHOULD BE KEPT WITHIN 12 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO. 2379		
1- FOR STATE REGISTRAR														
1. DECEASED NAME (TYPE OR PRINT)		FIRST			MIDDLE		LAST			2a DATE KNOWN OF ESTI- DEATH MATED		2b HOUR		
		WILLIAM			L.		TAYLOR			<input checked="" type="checkbox"/> Apr. 11 1986		M		
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YR. MONTHS DAYS		8. IF UNDER 24 HRS. HOURS MIN		2c. DATE PRONOUNCED DEAD		2d HOUR
Male		Black		2 23 35		51 yrs.						Apr. 11 1986		3:30p
9. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?										8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		
Wash., D. C.		USA												
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)										12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY
Ft. Wash., Md.		12907 Dauphin Ct.										Disabled		None
13. RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE		14. COUNTY		13e CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS						
D. C.				Washington				518 Chesapeake St. S.E.						
14. FATHER'S NAME FIRST		MIDDLE		LAST		15. MOTHER'S MAIDEN NAME FIRST		MIDDLE		LAST				
William				Taylor		Mildred				Johnson				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.										17. INFORMANT ADDRESS		
No		578-44-3132										Mrs. Ruby M. Carter/aunt/10125 Prince Pl. Largo, Md.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIOMYOPATHY													APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last.														
(b) DUE TO, OR AS A CONSEQUENCE OF														
(c)														
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 Diabetes mellitus														
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?										20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)										
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE				
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .														
ACTUAL SIGNATURE <i>Augusto P. Rodriguez</i>		TITLE (SPECIFY) M.D. Deputy MEDICAL EXAMINER										DATE SIGNED 4/11/1986		
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS 5009 Rayburn Ct, Temple Hills, Md.												
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE Burial 4-16-86		23c. NAME OF CEMETERY OR CREMATORIAL Lincoln Memorial		23d. LOCATION CITY OR TOWN Suitland,		COUNTY Md.		STATE Md.				
24. FUNERAL DIRECTOR NAME		ADDRESS John T. Rhines Co., 3015 12th St. N.E. D.C. 20001										25a. DATE REC'D. BY REGISTRAR APR 16 1986		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

reigned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 8612380				
1 - STATE REGISTRAR			1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR		
			DOROTHY LUE THACKSTON						APRIL 4 1986			5:50A M		
3. SEX			4. RACE			5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		
FEMALE			BLACK			SEPT 28, 1944			41			MONTHS DAYS		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. STATUS MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD. Prince George's		
SOUTH CAROLINA			U.S.A.											
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY					
Lanham			Doctors' Hospital of Pr. Geo. Co.			COUSTODIAN			HOSPITAL			20801		
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE 8106 GEORGE PALMER HWY #632		
MARYLAND			P.G.			GLENARDEN								
14. FATHER'S NAME FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST											
BRUCE CHEEKS			LOIS WESTFIELD											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)			17. INFORMANT			ADDRESS					
NO			249-72-0773			BRUCE CHEEKS, 2614 WINDBREAK DR., ALEX., VA								
18. CAUSE OF DEATH (Enter only one cause per line for 1a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Carcinoma</i>												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>a Carcinoma of rt. breast (removed)</i>												1585		
DUE TO, OR AS A CONSEQUENCE OF (c) <i>a Carcinoma of rt. breast (removed)</i>														
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a														
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY STATE		
22a. I certify that (I) this hospital attended the deceased from <i>19.79</i> to <i>4-4-86</i> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. I (we) did not view the body after death.														
22b. DATE SIGNED <i>4-4-86</i>														
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS Ronald P. Hairston, M.D.			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE <i>4/10/86</i>			23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS 7474 LANDOVER ROAD J.B. JENKINS FUNERAL HOME, LANDOVER, MARYLAND			23d. LOCATION CITY OR TOWN ANDERSON CO., SOUTH CAROLINA			COUNTY STATE		
24. FUNERAL DIRECTOR NAME J.B. JENKINS FUNERAL HOME, LANDOVER, MARYLAND						25a. DATE REC'D. BY REGISTRAR <i>APR 10 1986</i>			25b. REGISTRAR'S SIGNATURE <i>Julia Anderson-Pandell</i>					
DHMH - 16 60M 7/84 (VRA 15, 4)														

00-04227

1 - STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8012381
REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			20. DATE OF DEATH MONTH DAY YEAR			
<i>Marshall L. Thomas</i>						4 17 86			
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY) IF UNDER 1 YEAR MONTHS DAYS		
Male		Black		1 12 94			92 92 yrs.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH <i>PG</i>		
Wash., D.C.		USA					MD.		
10. CITY OR TOWN OF DEATH <i>Md.</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY		
		<i>Washington Adventist Hospital</i>					<i>Bd. of Education</i>		
13a. STATE <i>Md.</i>		13b. COUNTY <i>PG</i>		13c. CITY OR TOWN <i>W. Hyattsville</i>			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
							13e. STREET ADDRESS / ZIP CODE <i>1009 Chillum Road 20782</i>		
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST							
Unknown		Unknown							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT			ADDRESS		
No		578-54-6723-T		Ms. Lucille H. Spencer/friend/4833 16th					
18. CAUSE OF DEATH (Enter only one cause per line for Part I and II.) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		St. N.E.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
<i>912</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		<i>Respiratory Arrest</i>							
(b)		DUE TO, OR AS A CONSEQUENCE OF <i>Severe Bilateral Pneumonia</i>							
(c)		DUE TO, OR AS A CONSEQUENCE OF <i>Aspiration</i>							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>Metastatic Carcinoma of the prostate</i>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET		CITY OR TOWN		COUNTY STATE
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I/we) did (did not) view the body after death.									
22b. SIGNATURE <i>R. S. Locke, III M.D.</i>		DEGREE <i>M.D.</i>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <i>4/17/86</i>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>4-21-86</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Lincoln Memorial</i>		23d. LOCATION CITY OR TOWN <i>Suitland</i>		23e. COUNTY STATE	
24. FUNERAL DIRECTOR NAME <i>John T. Rhines Co., 3015 12th St. N.E.D.C. 20017</i>		ADDRESS		25a. DATE REC'D. BY REGISTRAR/25b. REGISTRAR'S SIGNATURE <i>APR 21 1986</i>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbamylpers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 18 is marked as "any injury" or other traumatic event, the medical examiner must be notified at once.

15810-00



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be retained with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 18 shows any injury, or other traumatic event, the medical examiner should be notified within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO. 8012382			
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR			
Jesse Willard Thompson						April 24 1986						5:55 a.m.			
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR MONTHS DAYS			IF UNDER 24 HRS HOURS MIN.		
MALE		WHITE		SEPT. 26, 1919			66			YRS					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8			MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH			Prince George's MD.		
W. VA.		U.S.A.													
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)										12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Riverdale		Leland Memorial										RET.-ELECTRICIAN		CAPITOL ELEC. CO.	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)												13e. STREET ADDRESS / ZIP CODE			
13a. STATE Md.		13b. COUNTY P.G.C.		13c. CITY OR TOWN HYATTSVILLE			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE 5902 31st. AVE. #506 20782					
14. FATHER'S NAME FIRST		MIDDLE		LAST			15. MOTHER'S MAIDEN NAME FIRST			MIDDLE			TATE		
MARION				THOMPSON			MYRTLE								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT			ADDRESS								
YES		WWII		236-01-7324			THELMA THOMPSON			(SAME AS ITEM #13)					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Massive Cerebral Infarction.</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>C.Bilateral</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
} (c) <u>Uncontrolled hypertension.</u> } DUE TO, OR AS A CONSEQUENCE OF } (d) <u>Atherosclerosis (generalized)</u>															
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a <u>ASPIRATION Pneumonia. (2) Hypertensive Cardiovascular Disease</u>															
19a. MEDICAL CERTIFICATION DATE OF OPERATION 4/7/86.		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED ② Feeding Jejunostomy. ② ③ Tracheostomy.			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED N/A										
21d. INJURY OCCURRED WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT HOME <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY	STATE				
22a. I certify that (I) (this hospital) attended the deceased from <u>3/23/86</u> to <u>4/12/86</u> , that (I) (we) last saw the deceased alive on <u>4/12/86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (and) (did not) view the body after death.															
22b. SIGNATURE <u>Shrinivas Udapi, MD</u>		22c. DEGREE . MD			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22d. DATE SIGNED 4/24/86							
22e. PHYSICIAN'S NAME (TYPE OR PRINT) Shrinivas Udapi, M.D.		22f. ADDRESS 6005 Landover Rd., Landover, Md. 20785													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION		23b. DATE 4-24-1986		23c. NAME OF CEMETERY OR CREMATORIAL CHAMBERS CREMATORY			23d. LOCATION CITY OR TOWN RIVERDALE, P.G.C. Md.			23e. COUNTY STATE					
24. FUNERAL DIRECTOR NAME W. W. CHAMBERS CO.		ADDRESS RIVERDALE, MD. 20737			25a. DATE REC'D. BY REGISTRAR APR 28 1986			25b. REGISTRAR'S SIGNATURE <u>S. David Wilson, R.N.P.</u>							

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00-03128

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 11 2383
REG. NO.

1 - STATE REGISTRAR

1. DECEASED NAME [TYPE OR PRINT]			FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR							
<i>MARY H. THOMPSON</i>						04	06	86		10:45PM							
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR			IF UNDER 24 HRS						
Female		White		August 30, 1908		77		MONTHS	YEARS	MONTHS	YEARS						
7a. BIRTHPLACE COUNTRY		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH		10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION [IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS]		12a. USUAL OCCUPATION		12b. KIND OF BUSINESS OR INDUSTRY	
Arkansas		U.S.A.				PRINCE GEORGE		Clinton				Southern Md Hospital		Administrator		U.S. Gov't.	
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS / ZIP CODE				14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME			
Maryland		Prince Georges		Oxon Hill		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		5617 Fargo Avenue 20745				Noah		Hattie		Hastings	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? [YES, NO, UNKNOWN]		16b. SOCIAL SECURITY NO. [IF YES, GIVE WAR OR DATES]		17. INFORMANT		ADDRESS		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
No		432-26-3660		Mrs. Mary M. McCollum, Daughter, 10701 Stammore Drive, Potomac, Maryland 20854				<i>Respiratory Failure</i>				Minutes, Years					
19a. MEDICAL CERTIFICATION		19b. DUE TO, OR AS A CONSEQUENCE OF (b) <i>Chronic Obstructive Lung Disease</i>		19c. DUE TO, OR AS A CONSEQUENCE OF (c)		20. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>											
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH [IF EITHER, NOTIFY MEDICAL EXAMINER]		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)													
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE							
22a. I certify that (I) <i>the hospital</i> attended the deceased from <i>3/16</i> , 19 <i>86</i> , to <i>4/6</i> , 19 <i>86</i> , that (I) <i>did not</i> lost saw the deceased alive on <i>4/6</i> , 19 <i>86</i> , and that in (my) <i>own</i> opinion death occurred on the date and hour and from the causes stated above, (I) <i>did not</i> view the body after death.																	
22b. SIGNATURE <i>L. K. KRAMAN</i>		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <i>4/10/86</i>											
22d. PHYSICIAN'S NAME, TITLE OR RANK <i>L. K. KRAMAN</i>		22e. ADDRESS <i>8926 Woodlawn Rd. Clinton, Md.</i>															
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE <i>Burial 4/10/86</i>		23c. NAME OF CEMETERY OR CREMATORIAL <i>Ft. Lincoln Cemetery</i>		23d. LOCATION CITY OR TOWN <i>Brentwood, Maryland</i>		COUNTY		STATE							
24. FUNERAL DIRECTOR NAME <i>Joseph Gawler's Sons, Inc.</i>		ADDRESS <i>5130 Wisconsin Avenue, N.W., Washington, DC 20016</i>		25a. DATE REC'D. BY REGISTRAR <i>APR 10 1986</i>		25b. REGISTRAR'S SIGNATURE <i>Julie Dawson-Randall</i>											

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be detached for use as the burial/transit permit. Then please remove carbon copy (item 18) and 21 (should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal).

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of the same.

executed within 24 hours after death. Page 4 may be completed filled in by the funeral director, page 3 and completely filled in by the medical examiner, pages 1, and 2 (should be filed within 72 hours of death).

referred by the hospital or attending physician.

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00-02929

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REC. NO. 8812384

1. FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)		FIRST NORMAN C	MIDDLE	LAST THOMPSON	SR.	DATE OF DEATH MONTH DAY YEAR	MONTH DAY YEAR	2d. HOUR 10:24AM			
2. SEX		4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY) YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		IF UNDER 24 HRS. MONTHS DAYS HOURS MIN.				
Male		Caucasian	June 7, 1921	64							
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's		10. CITY OR TOWN OF DEATH Lanham			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Doctors' Hospital of Pr. Geo. Co.	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired	12b. KIND OF BUSINESS OR INDUSTRY Television repa
13a. STATE Maryland		13b. COUNTY Prince Georges	13c. CITY OR TOWN Bowie	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 6817 Hillmeade Rd. 20715						
14. FATHER'S NAME FIRST Norman		MIDDLE (NMI)	LAST Thompson	15. MOTHER'S MAIDEN NAME FIRST Priscilla	MIDDLE L.	LAST Coale					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. 577-26-0066	17. INFORMANT Mildred C. Thompson	18. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:		Cardiorespiratory arrest									
		IMMEDIATE CAUSE (a) ventricular arrhythmia									
		DUE TO, OR AS A CONSEQUENCE OF (b) Diabetes mellitus									
		DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last									
19. MEDICAL CERTIFICATION		20. PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a Surgery disorder.									
19a. DATE OF OPERATION —		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED —		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN	COUNTY	STATE			
22a. I certify that (I) (this hospital) attended the deceased from January 19, 82 to April 15, 1986 , that (I) (—) last saw the deceased alive on Mar 27, 1986 and that in my (—) opinion death occurred on the date and hour and from the causes stated above, (I) (—) did not view the body after death.											
22b. SIGNATURE David A. Boetcher		22c. DEGREE MD		22d. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22e. DATE SIGNED 4-3-86					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) David Boetcher, M.D.		22e. ADDRESS 14300 Gallant Fox Lane, Bowie, Md. 20715									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE April 5 1986		23c. NAME OF CEMETERY OR CREMATORIAL Ft. Lincoln Cemetery		23d. LOCATION CITY OR TOWN Brentwood, Maryland					
24. FUNERAL DIRECTOR NAME R. Beall		ADDRESS 16000 Annapolis Rd.		25a. DATE REC'D. BY REGISTRAR APR 08 1986		25b. REGISTRAR'S SIGNATURE John Pendle					
Beall Funeral Home		Bowie, Maryland									

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be referred to by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be laid within 72 hours after death, with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 18 shows any injury, or other traumatic event, the medical examiner should be notified.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page should be detached for use as the burial-transit permit. Then please remove carbon paper, Pages 1 and 2 should be filed in the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or if Item 18 shows any injury, or other traumatic event, medical examiner must be called.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										8612385			
A.K.A. First Name-Eugenia CERTIFICATE OF DEATH										REG. NO.			
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST		2d. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR	
Geno			M.		Thornhill		April 14, 1986					1:30 P.M.	
3. SEX			4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS		
Female			White		Jan. 23, 1907		79		YRS		MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH		Prince George's County MD.				
Maryland			U.S.A.										
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY						
Greenbelt			8 - Forest Way		Phys.Ed.Instructor State of Md.								
13a. STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE				
Maryland			P.G.		Greenbelt		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		8 - Forest Way 20770				
14. FATHER'S NAME FIRST			MIDDLE		LAST		15. MOTHER'S MAIDEN NAME FIRST		MIDDLE		LAST		
Eugene					Miles		Bessie				Riggins		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.		17. INFORMANT		18. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH						
No			217-70-9881		Mr. Tom Walker-Attorney- Landover, Maryland								
18. CAUSE OF DEATH (Enter only one cause per line for 1a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)										CARCINOMA OF RIGHT LUNG			
DOUE TO, OR AS A CONSEQUENCE OF (b) CONGESTIVE HEART FAILURE													
DOUE TO, OR AS A CONSEQUENCE OF (c) CORONARY ARTERY DISEASE													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1b CHRONIC PULMONARY ARTERY DISEASE													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE		
22a. I certify that (I) (this hospital) attended the deceased from 11-16, 19 85, to 4.14, 19 86, that (I) (we) last saw the deceased alive on 3-30 19 86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE VP Singh			DEGREE M.D.		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED Apr. 14, 1986						
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Virender P. Singh, M.D.			22e. ADDRESS 5632 Annapolis Rd. #9 Bladensburg, Md.										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 4-17-86		23c. NAME OF CEMETERY OR CREMATORIAL Crisfield Cemetery		23d. LOCATION CITY OR TOWN Crisfield		COUNTY Somerset		STATE Md.		
24. FUNERAL DIRECTOR NAME F. Gasch's Sons F.H. P.A. Hyattsville, Maryland			ADDRESS		25a. DATE REC'D. BY REGISTRAR APR 21 1986		25b. REGISTRAR'S SIGNATURE Julia Davidson-Kendall						

(above - see 3rd point)

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REFERENCES

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$$\frac{P^{\text{opt}} - P_{\text{min}}}{P_{\text{max}}} = \left(\frac{P^{\text{opt}}}{P_{\text{max}}} \right)^2 = \left(\frac{A}{B} \right)^2 = \frac{A^2}{B^2} = \frac{P^{\text{opt}}}{P_{\text{max}}} \cdot \frac{P^{\text{opt}}}{P_{\text{max}}} = \frac{P^{\text{opt}}}{P_{\text{max}}}.$$

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Indra, son of Kasyapa, was born from the egg of a golden swan.

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the authorship of the following code.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by [REDACTED] (either director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper). Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or if item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
REG. NO. 3012386											
1. DECEASED NAME (TYPE OR PRINT)			FIRST aka Harris			LAST Thornton			2a. DATE OF DEATH MONTH DAY YEAR		
JANIE FREEMAN									April 9, 1986		
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)		
FEMALE			White			MONTH 04 DAY 21 YEAR 06			IF UNDER 1 YEAR 79 YRS		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8			IF UNDER 24 HRS		
Virginia			USA			MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			MONTHS DAYS HOURS MIN.		
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OR PRINT WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY		
7t. Washington			7t. Washington Rehab Ctr.			Homemaker			ODD jobs Babysitting Home		
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
MD			P.G.			CLINTON			13e. STREET ADDRESS / ZIP CODE 8715 JENNIFER Court		
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME								
# John West			Unknown								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS		
No			N/A			ORA STANCILL			7t. Wash, MD.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY:									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
IMMEDIATE CAUSE (a)			cardiopulmonary arrest						minutes		
DUE TO, OR AS A CONSEQUENCE OF (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost			stroke other than coronary heart disease						years		
DUE TO, OR AS A CONSEQUENCE OF (c) cardiovascular & chronic atrial fibrillation									years		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
Severe senile dementia, hx of seizure disorder, peripheral arterial occlusive disease											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
						<input type="checkbox"/> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from JUNE 20, 1984, to APRIL 9, 1986, that (I) (we) last saw the deceased alive on APRIL 9, 1986, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <i>Peter W. Jim</i>			DEGREE M.D.			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> MEDICAL STAFF <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED Apr. 9, 1986		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Peter W. Jim M.D.						22e. ADDRESS 7900 Old Branch Ave. Suite 101 Clinton, Maryland 20735					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation			23b. DATE 04/12/86			23c. NAME OF CEMETERY OR CREMATORIAL Lee Crematory			23d. LOCATION CITY OR TOWN Clinton COUNTY MD. STATE		
24. FUNERAL DIRECTOR NAME Lee Funeral Home, Inc. ADDRESS 6633 Old Alexander Ferry Rd. Clinton Md. 20735						25a. DATE REC'D. BY REGISTRAR APR 11 1986			25b. REGISTRAR'S SIGNATURE <i>J. ...</i>		

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, then please remove carbon papers. Pages 1 and 2 should be detached for use on the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be retained by the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked at item 18 show any injury, or other traumatic event, the medical examiner

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 8612367
1 - STATE REGISTRAR 1. DECEASED NAME FIRST MIDDLE LAST Rosa L. Trotta				2a. DATE OF DEATH MONTH DAY YEAR April 5, 1986 2b. HOUR 6:05PM
3. SEX Female		4. RACE White		5. DATE OF BIRTH Feb. 3 1904
7a. BIRTHPLACE (STATE OR FOREIGN <small>CONT'D)</small> Washington, DC		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
10. CITY OR TOWN OF DEATH Riverdale		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION <small>IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS</small> Leland Memorial Hospital		12a. USUAL OCCUPATION <small>TYPE OF WORK FOR MOST OF WORKING LIFE</small> Retired
12. STATE Maryland		13b. COUNTY Pr. Georges Hyattsville		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME <small>FIRST MIDDLE LAST</small> Nicholas Meola		15. MOTHER'S MAIDEN NAME <small>FIRST MIDDLE</small> Antoinette (unk)		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? <small>(YES NO UNKNOWN)</small> N/A		16b. SOCIAL SECURITY NO. <small>(IF YES, GIVE NAME OR DATES)</small> 579-58-4951		17. INFORMANT Mary Mudd -daughter- ADDRESS 9929 Cottrell Terrace Silver Spring, Md.
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIAC ARREST DUE TO, OR AS A CONSEQUENCE OF (b) A2o temia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) CANCER BREAST DUE TO, OR AS A CONSEQUENCE OF				
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)				
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH <small>(IF EITHER NOTIFY MEDICAL EXAMINER)</small>		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)
21d. INJURY OCCURRED <small>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/></small>		21e. PLACE OF INJURY <small>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)</small>		21f. LOCATION <small>STREET CITY OR TOWN COUNTY STATE</small>
22a. I certify that (I) (this hospital) attended the deceased from 9-9-1983 to 4-5-1986 , that (I) (we) last saw the deceased alive on 3-28 1986 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.				
22b. SIGNATURE Tony P. Kannarkat		DEGREE MD		22c. DATE SIGNED 4/7/86
22d. PHYSICIAN'S NAME (TYPE OR PRINT) TONY P. KANNARKAT		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22e. ADDRESS Suite #121 8201 16th. St., Silver Spring, Md.
23a. BURIAL, CREMATION, REMOVAL <small>(SPECIFY)</small> Burial		23b. DATE 4-9-1986		23c. NAME OF CEMETERY OR CREMATORIAL Ft. Lincoln Cemetery
24. FUNERAL DIRECTOR <small>NAME</small> Hines/Rinaldi Funeral Home		25a. DATE REC'D. BY REGISTRAR APR 07 1986		25b. REGISTRAR'S SIGNATURE Wendell

TELEGRAM

TO THE SECRETARY

A&E CO. - 25000

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TELEGRAM

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B, AND TO THE FUNERAL DIRECTOR, PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM RM 1. RETAIN PAGES 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

1- STATE REGISTRAR		STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 2 3 8 8			
DECEASED NAME (TYPE OR PRINT)		FIRST JOHN			MIDDLE FRANKLIN			LAST TUCKER, JR.			2a. DATE KNOWN OF ESTI- DEATH MATED	MONTH 4	DAY 17	YEAR 1986	2b. HOUR M
1. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH 09 DAY 13 YEAR 1957		6. AGE (IN YEARS LAST BIRTHDAY) 28 YRS.		IF UNDER 1 YR. MONTHS		IF UNDER 24 HRS. DAYS		HOURS		MIN		2d. HOUR 12:07 p.m	
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington, D.C.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.				8. MARRIED WIDOWED		NEVER MARRIED DIVORCED		9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's County MD.		PRONOUNCED DEAD		4 17 1986	
10. CITY OR TOWN OF DEATH Cheverly		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Prince George's General Hosp.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Painter				12b. KIND OF BUSINESS OR INDUSTRY Self Employed					
13a. STATE Maryland		13b. COUNTY Prince George's		13c. CITY OR TOWN Mt. Rainier		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 3810 32nd Street 20712							
14. FATHER'S NAME John		MIDDLE F.		LAST Tucker, Sr.		15. MOTHER'S MAIDEN NAME Velma		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No				17. INFORMANT Tucker John F. Franklin, Sr. (Father) Same as #13			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cranio-cerebral trauma DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)														APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1.															
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?										20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR XX MONTH DAY YEAR 10:30M. 4-17- 1986		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) Subject was hit and fell and struck head.											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) parking lot		21f. LOCATION STREET 3812 38th St., Brentwood, Prince George's, MD		CITY OR TOWN		COUNTY		STATE					
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input checked="" type="checkbox"/> , Undetermined manner <input type="checkbox"/> .															
ACTUAL SIGNATURE 		TITLE (SPECIFY) M.D. Assistant MEDICAL EXAMINER												DATE SIGNED 4-18-86	
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS 111 Penn St., Balto., MD 21201													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE Burial 4/21/86		23c. NAME OF CEMETERY OR CREMATORIAL Fort Lincoln Cemetery		23d. LOCATION CITY OR TOWN Brentwood		COUNTY		STATE					
24. FUNERAL DIRECTOR NAME Francis Gasch's Sons Funeral Home, P.A. 4739 Baltimore Avenue Hyattsville, Md. 20781		25a. DATE REC'D. BY REGISTRAR APR 21 1986		25b. REGISTRAR'S SIGNATURE 											
BP		DHMH - 17 (VR A15 ME (S))													

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1 - FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REC. NO.

1 2 3 8 9

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be reigned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked (Item 21), who(s) any injury, or other traumatic event, the medical examiner must be notified at once.

1 DECEASED NAME (TYPE OR PRINT)			FIRST WILLIAM	MIDDLE A.	LAST TURNER Sr.	2a DATE OF DEATH 04 12 86	MONTH	DAY	YEAR	2b HOUR 6 34PM	
3. SEX Male			4 RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR July 27, 1905		6 AGE (IN YEARS LAST BIRTHDAY) 80 yrs			IF UNDER 1 YEAR MONTHS DAYS	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) West Virginia			7b CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince Georges MD.				
10 CITY OR TOWN OF DEATH Cheverly			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Prince Georges General Hospital		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired		12b. KIND OF BUSINESS OR INDUSTRY Pottery				
13a. STATE Maryland			13b. COUNTY Prince Georges		13c. CITY OR TOWN Hyattsville		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE 7728 Garrison Road 20784	
14. FATHER'S NAME FIRST Lafayette			MIDDLE F.	LAST Turner	15. MOTHER'S MAIDEN NAME Mary E. Carper						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no			16b. SOCIAL SECURITY NO. 578-10-6650A		17. INFORMANT Florence I. Turner		ADDRESS same as 13e				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIOPULMONARY ARREST APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
DUE TO, OR AS A CONSEQUENCE OF (b) ASCVD											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.											
DUE TO, OR AS A CONSEQUENCE OF (c) SENILE DEMENTIA											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY	STATE	
22a. I certify that (I) (this hospital) attended the deceased from 10-18-76, to Feb 7, 1986, that (I) (we) last saw the deceased alive on 4-12-1986, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.											
22b. SIGNATURE <i>JK Yoon M.D.</i>			22c. DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22d. DATE SIGNED 4/13/86				
22e. PHYSICIAN'S NAME (TYPE OR PRINT) YEAR-KWON H. YOON			22f. ADDRESS 5506 KENILWORTH AVE. RIVERDALE, MD. 20737								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE April 15 1986		23c. NAME OF CEMETERY OR CREMATORIUM Ft. Lincoln Cemetery		23d. LOCATION CITY OR TOWN Brentwood, Maryland				
24. FUNERAL DIRECTOR NAME Beall Funeral Home			16000 Annapolis Rd. ADDRESS Bowie, Maryland		25a. DATE REC'D. BY REGISTRAR APR 15 1986		25b. REGISTRAR'S SIGNATURE <i>John Pendle</i>				

- 2 -

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be submitted within 24 hours after death. Please be advised.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO. 8012390						
1 - STATE REGISTRAR			2a. DATE OF DEATH MONTH DAY YEAR April 17, 1986									2b. HOUR 3:45 PM						
1. DECEASED NAME FIRST MIDDLE LAST Lorain V. Utter			3. SEX Female			4. RACE Caucasian			5. DATE OF BIRTH MONTH DAY YEAR March 10, 1910			6. AGE (IN YEARS LAST BIRTHDAY) 76 YRS			IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) South Carolina			7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's County MD.									
10. CITY OR TOWN OF DEATH Cheverly			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Prince George's General Hosp			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker			12b. KIND OF BUSINESS OR INDUSTRY own home									
13a. STATE Maryland			13b. COUNTY Pr George's			13c. CITY OR TOWN Bladensburg			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE 3801 Kenilworth Avenue 20710						
14. FATHER'S NAME FIRST Charles			MIDDLE Carter			15. MOTHER'S MAIDEN NAME FIRST Rosalie			MIDDLE			LAST Melton						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO			16b. SOCIAL SECURITY NO. 558-20-0371			17. INFORMANT Joe Craig			ADDRESS 12622 Heming Lane Bowie, Maryland 20716			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Massive myocardial infarction</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. (b) <u>coronary thrombosis</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>arteriosclerotic heart disease</u>																		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a																		
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)												
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY		STATE					
22a. I certify that (I) (this hospital) attended the deceased from 1984 to APRIL 17 86, that (I) (we) last saw the deceased alive on APRIL 17 86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																		
22b. SIGNATURE <u>Don B. Cameron MD</u>			DEGREE			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 4-18-86									
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Don B. CAMERON</u>			22e. ADDRESS 6005 Landover Road CHEVERLY MD 20785															
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE APR 19, 1986			23c. NAME OF CEMETERY OR CREMATORIAL Ft. Lincoln Cemetery			23d. LOCATION CITY OR TOWN Brentwood, Pr. George's, MD			COUNTY		STATE				
24. FUNERAL DIRECTOR NAME Beall Funeral Home			16000 Annapolis Road			25a. DATE REC'D. BY REGISTRAR APR 24 1986			25b. REGISTRAR'S SIGNATURE <u>Jane L. Johnson</u>									
Kurt Ahrens			Bowie, MD 20715															



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 8 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO. 8612391	
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2d. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR	
Clara Constance Vallandingham						April 7 '86						234	
3. SEX			4 RACE	W	5. DATE OF BIRTH	MONTH	DAY	YEAR	6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR MONTHS	IF UNDER 24 HRS DAYS
F					9	9	1890	95 YRS.					
7a. BIRTH PLACE COUNTRY			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH				
PRINCE GEORGES CO., MD.			USA						PRINCE GEORGES MD.				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY				
Clinton			10302 BRANDYWINE RD.			HOUSEWIFE			NONE				
13a. STATE			13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS					
MD.			PRINCE GEORGES	CLINTON				10302 BRANDYWINE RD.					
14. FATHER'S NAME			FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME			FIRST	MIDDLE	LAST		
JOHN WILLIAM YOUNG						MARY ANN TRUEMAN							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS				
NO			215-50-0771			NEPHEW			CLINTON, MD 20735				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) RESPIRATORY FAILURE												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DOES NOT APPLY												10 MIN.	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) CERERROVASCULAR ACCIDENT												41 YRS.	
DUE TO, OR AS A CONSEQUENCE OF (c) GENERALIZED ARTERIOSCLEROSIS 20 YRS													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) None													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?				
None			None			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (ENTER BY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN DEATH CERTIFICATE)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT HOME <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN				
22a. I certify that (I) (the hospital) attended the deceased from saw the deceased alive on APRIL 6 '86, and that in (my) opinion death occurred on the date and hour and from the causes stated above. (I) (we did) (did not) view the body after death.			22b. SIGNATURE ARTHUR SHAVER JR. M.D.			22c. DATE SIGNED 4/7/86							
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS 9131 PISCATAWAY RD CLINTON, MD 20735			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE 4-10-86			23c. NAME OF CEMETERY OR CREMATORIAL ESTATE CEMETERY			23d. LOCATION CITY OR TOWN CLINTON, MD			STATE MD.	
Burial													
24. FUNERAL DIRECTOR NAME LEE F.H. INC.			6633 600 ALEXANDER FERRY RD CLINTON, MD 20735			25a. DATE REC'D. BY REGISTRAR APR 11 1986			25b. REGISTRAR'S SIGNATURE Lee				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial permit sheet. Then attach the death certificate to the burial permit sheet and file it with the State Dept. of Health and Mental Hygiene prior to burial, cremation, removal or removal.

IMPORTANT: If item 21 is marked as Item 18 shows any injury, all information must be confirmed at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 8912392				
1 - STATE REGISTRAR			I. DECEASED NAME FIRST MIDDLE LAST			2d. DATE OF DEATH MONTH DAY YEAR			2b. HOUR					
I. DECEASED NAME (TYPE OR PRINT)			BERYL AGATHA VAN ROSSUM			4 23 86			12:00 P.M.					
3 SEX		4 RACE		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY) YRS.			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.				
FEMALE		BLACK		6 7 21			64							
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD PRINCE GEORGES				
GUYANA		U.S.A.												
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY							
TAKOMA		WASHINGTON ADVENTIST		TEACHER										
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)														
13a. STATE		13b. COUNTY		13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE					
D. C.				WASHINGTON			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		1300 SHEPHERD ST. N. W. 20011					
14. FATHER'S NAME FIRST		MIDDLE		LAST			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST							
Wilfred Fred Douglas							WINIFERED LANGFORD							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT			18. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			ADDRESS				
NO		579-74-1435A								WASHINGTON, D. C.				
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE														
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Cerebrovascular Arrest</u>														
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost														
DUE TO, OR AS A CONSEQUENCE OF (c) <u>Cerebrovascular Arrest</u>														
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)														
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET		CITY OR TOWN			COUNTY		STATE		
22a. I certify that (I) (we) attended the deceased from <u>April 21, 1986</u> to <u>April 22, 1986</u> , that (I) (we) last saw the deceased alive on <u>April 13, 1986</u> , and that in (my) (our) opinion death occurred on the date and hour and from the cause(s) stated above. (I) (we) did not view the body after death.														
22b. SIGNATURE										DEGREE				
<u>Adam Blackman</u>										ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				
22d. PHYSICIAN'S NAME (TYPE OR PRINT)										22e. ADDRESS				
Adam Blackman										10500 Summit Ave, Kensington MD				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN		CITY OR TOWN		COUNTY		STATE	
BURIAL		5/1/86		WASHINGTON NATIONAL			SUITLAND						MARYLAND	
24. FUNERAL DIRECTOR NAME		SAM BUTLER INC. FUNERAL SERVICE 716 KENNEDY ST. N. W. D. C.						25. DATE REC'D. BY REGISTRAR			FEBR. 29 1986			

02910-00



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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3, RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO. 2373			
1. FOR 1 - STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT)			FIRST		MIDDLE		LAST		2a. DATE KNOWN OF ESTI- DEATH MATED				
		<i>Ernest Randolph Violett Sr.</i>									APRIL 27 1986				
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS) LAST BIRTHDAY		7. IF UNDER 1 YR. MONTHS DAYS		8. IF UNDER 24 HRS. HOURS MIN.		2b. HOUR 1/30 P.M.			
M		W		JULY 16 1898 87		YRS.									
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED WIDOWED <input checked="" type="checkbox"/> DIVORCED		9. BALTIMORE CITY OR COUNTY OF DEATH		10c. DATE PRONOUNCED DEAD		10d. HOUR 4:30 P.M.					
WASHINGTON, D.C.		U.S.A.				Prince Georges MD		April 27 1986							
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY			
College Park		3737 Marlborough Way						SYSTEMS MANAGER HECHT CO/RET				20740			
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS					
College Park		MD		Prince George's County		College Park		YES <input checked="" type="checkbox"/>		3737 Marlborough Way					
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS					
RANDOLPH		ROSA		YES		W.W.I		ERNEST R. VIOLETT, JR.		3737 Marlborough Way					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute myocardial Dvt.</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____														APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a). <i>None</i>															
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?										20. AUTOPSY?			
None												YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) P.M. 19											
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21d. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21e. LOCATION STREET		CITY OR TOWN		COUNTY		STATE					
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>														DATE SIGNED <i>April 27 1986</i>	
ACTUAL SIGNATURE <i>John S. Rogers, M.D.</i> MEDICAL EXAMINER															
EXAMINER'S NAME (TYPE OR PRINT) <i>John S. Rogers</i>															
ADDRESS <i>1919 Seminary Rd., S. S., Md.</i>															
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE Burial May 1, 1986		23c. NAME OF CEMETERY OR CREMATORIAL Mount Olivet Cemetery		23d. LOCATION CITY OR TOWN Washington		COUNTY		STATE					
24. FUNERAL DIRECTOR		ADDRESS <i>Taylor Funeral Home, Inc., 254 Carroll Dr. NW</i>		25a. DATE REC'D. BY REGISTRAR APR 30 1986		25b. REGISTRAR'S SIGNATURE <i>John S. Rogers</i>									

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in full, it may be filed in the funeral director's office. It should be retained for use as the burial/transit permit. Then please remove carbon copies, sign 1 and 2 and file within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REC. NO. 2344	
1 - STATE REGISTRAR			1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			20. DATE OF DEATH MONTH DAY YEAR			26 HOUR	
			EMMA M. VOLTA						4 - 3 - 86			10:30 PM	
3. SEX			4. RACE			5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
FEMALE			WHITE			JUNE 4 1918			67 YRS			IF UNDER 24 MRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) NEW YORK			7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGE'S COUNTY			MD.	
10. CITY OR TOWN OF DEATH CLINTON			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SOUTHERN MARYLAND HOSPITAL CENTER						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) CASE WORKER			12b. KIND OF BUSINESS OR INDUSTRY US CONGRESS	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)												80747	
13a. STATE MARYLAND			13b. COUNTY PRINCE GEO DIST HGTS			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE 2300 ROSLYN AVENUE	
14. FATHER'S NAME RICHARD MASSONI									15. MOTHER'S MAIDEN NAME MARIA PELLEGRINI			LAST	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO			16b. SOCIAL SECURITY NO. (IF YES GIVE WAR OR DATES) 577-16-2135			17. INFORMANT ARMAND J VOLTA, SPOUSE SAME AS #13			ADDRESS			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 yr	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Bilateral Hypopharyngeal Squamous cell cancer with metastases to cervical lymph nodes</i>													
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) (c) DUE TO, OR AS A CONSEQUENCE OF													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY	STATE
22a. I certify that (I) (this hospital) attended the deceased from <i>May 1985</i> to <i>April 1986</i> , that (I) (we) last saw the deceased alive on <i>4-3-86</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE <i>Lai-Yiu Yeung</i>			22c. DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22d. DATE SIGNED 4-4-86				
22e. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Lai-Yiu YEUNG, M.D.</i>			22f. ADDRESS 8926 Woodyard Rd # 201 Clinton, MD 20735										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE 04/07/86			23c. NAME OF CEMETERY OR CREMATORIAL MD VET CEMETERY			23d. LOCATION CITY OR TOWN CHELTENHAM PG MARYLAND			23e. COUNTY STATE	
24. FUNERAL DIRECTOR Robert E. Wilhelm Funeral Home 4308 Suitland Road, Suitland Maryland									25a. DATE REC'D. BY REGISTRAR 1986-04-07			25b. REGISTRAR'S SIGNATURE <i>Robert E. Wilhelm</i>	



8210-200

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORMS 1, 2, AND 3. (REMAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 WOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO. 1 2 3 9 5					
1- STATE REGISTRAR				2a. DATE KNOWN <input checked="" type="checkbox"/> OF ESTI- DEATH MATED <input type="checkbox"/>								MONTH DAY YEAR	2b HOUR				
1. DECEASED NAME (TYPE OR PRINT)				FIRST		MIDDLE		LAST									
Brady John Vradenburg												4/ 16/ 19 86	M				
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN		2c. DATE PRONOUNCED DEAD MONTH DAY YEAR		2d HOUR 1:26			
MALE		WHITE		MARCH 11, 1904		82 yrs.						4/ 16/ 19 86		P.M.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)				7b. CITIZEN OF WHAT COUNTRY?				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH					
MINN.				U.S.A.								Prince George's County, MD.					
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)								12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY	
Mt. Ranier				3702 Utah Ave.								ATTORNEY				LAW	
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS		ADDRESS							
Md.		P.G.C.		BRENTWOOD				3702 UTAH AVE. 20722		5970 WESTCHESTER PK. D. COLLEGE PARK, Md. #301							
14. FATHER'S NAME FIRST MIDDLE LAST				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST				16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <input checked="" type="checkbox"/> YES (IF YES, GIVE WAR OR DATES) WWII				16b. SOCIAL SECURITY NO. 460-64-4165				17. INFORMANT SUE JOHNSON	
WILBUR VRADENBURG				CATHERINE PHILLIPS													
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY:												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
IMMEDIATE CAUSE (a) Pulmonary Emboli DUE TO, OR AS A CONSEQUENCE OF																	
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF																	
(c)																	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)																	
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								2d AUTOPSY?					
												YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET				CITY OR TOWN		COUNTY STATE			
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>																	
ACTUAL SIGNATURE Dennis F. Smyth, M.D.												TITLE (SPECIFY) Assistant MEDICAL EXAMINER					
EXAMINER'S NAME (TYPE OR PRINT)				ADDRESS 111 Penn St.								DATE SIGNED 4/17/86					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION				23b. DATE 4-18-1986				23c. NAME OF CEMETERY OR CREMATORIAL CHAMBERS CREMATORY				23d. LOCATION CITY OR TOWN RIVERDALE,		COUNTY P.G.C. STATE Md.			
24. FUNERAL DIRECTOR NAME W. W. CHAMBERS CO.				ADDRESS RIVERDALE, Md. 20737								25a. DATE REC'D. BY REGISTRAR APR 22 1986		25b. REGISTRAR'S SIGNATURE Julie Dawson-Smyth			
DHMH - 17 (VR A15 ME (5))																	



BRIDGE

retained by the hospital or attending physician.

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8 6 1 2 3 9 6		
												REG. NO.		
1 - STATE REGISTRAR			I. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a DATE OF DEATH MONTH DAY YEAR			2b HOUR		
Angel Mary WALSH									April 11, 1986			9:40 p.m.		
3. SEX		4 RACE		5 DATE OF BIRTH MONTH DAY YEAR			6 AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.		
Female		White		April 10, 1890			96 yrs							
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH			MD.				
Pennsylvania		USA					Prince-Georges							
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b KIND OF BUSINESS OR INDUSTRY							
Hyattsville		Sacred Heart Home, Inc.		Teacher/Clerical G.A.O.										
13a STATE District of Columbia		13c CITY OR TOWN Washington		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e STREET ADDRESS / ZIP CODE 2101 - 16th Street 99999							
14. FATHER'S NAME FIRST John MIDDLE Joyce LAST		15. MOTHER'S MAIDEN NAME Anna			T. Langan									
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b SOCIAL SECURITY NO. NO 579-50-9463		17 INFORMANT Edna H. Joyce/4301 Columbia Pike,			Arlington, VA.			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 7 days				
18 CAUSE OF DEATH (Enter only one cause per line for 1a), (b) and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		DUE TO, OR AS A CONSEQUENCE OF (b) Chronic Cardio-Vascular-Nephritis 10 years												
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause, if any.		(c)												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a														
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a I certify that (I) (this hospital) attended the deceased from 8 April 1986 to 13 March 1986, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) did (did not) view the body after death.														
22b. SIGNATURE Robert C. Haile MD		22c. DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22d. DATE SIGNED 04/12/86									
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Robert C. Haile MD.		22e. ADDRESS 5109 Wisconsin Ave N.W. Wash. DC 20016												
23a. BURIAL, CREMATION, REMOVAL Burial		23b. DATE 4/16/86			23c. NAME OF CEMETERY OR CREMATORY Arlington National			23d. LOCATION CITY OR TOWN COUNTY STATE Arlington, Va.						
24a. FUNERAL DIRECTOR NAME Murphy Funeral Home-Arlington ADDRESS 4510 Wilson Blvd. Arlington, Va.		25a. DATE REC'D. BY REGISTRAR APR 16 1986			25b. REGISTRAR'S SIGNATURE Juliette Wilson Pendell									

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, file it in the funeral director's office. It should be detached for use as a burial-trust permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked **✓**, show any injury, or other traumatic event, the medical examiner will be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO. 8 6 2 3 9 7					
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR					
<u>Leona G. Walsh</u>						<u>April 5, 1986</u>						<u>0610 AM</u>					
3. SEX			4 RACE	5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS.					
<u>Female</u>			<u>White</u>	MONTH	DAY	YEAR	<u>89</u>			MONTH	DAYS	HOURS	MIN.				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8			9 BALTIMORE CITY OR COUNTY OF DEATH								
<u>S. C.</u>			<u>USA</u>			<u>MARRIED</u> <input type="checkbox"/> <u>NEVER MARRIED</u> <input type="checkbox"/> <u>WIDOWED</u> <input checked="" type="checkbox"/> <u>DIVORCED</u> <input checked="" type="checkbox"/>			<u>Prince Georges County MD.</u>								
10 CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)									12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)					
<u>Riverdale, Md.</u>			<u>Leland Memorial Hospital</u>									<u>Housewife</u>			12b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?			13e. STREET ADDRESS / ZIP CODE					
<u>Maryland</u>			<u>P.G.</u>			<u>Brentwood</u>			<u>YES</u> <input checked="" type="checkbox"/> <u>NO</u> <input type="checkbox"/>			<u>3705 Taylor Street 20722</u>					
14. FATHER'S NAME			FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME			LAST			Hamilton					
<u>R.J.C.</u>					<u>Ward</u>	<u>Elizabeth</u>						ADDRESS <u>6009 10th. Place</u>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			18. CAUSE OF DEATH (Enter only one cause per line for 18a, 18b, and 18c) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
<u>No</u>			<u>214-36-3275</u>						<u>Cardiac arrest -</u>								
18c. DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (18a), stating the underlying cause last			(b) <u>Cardio-respiratory disorder</u>			18d. DUE TO, OR AS A CONSEQUENCE OF (c) <u>Hepatoma - Seizures</u>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 18a. <u>Heroin</u>																	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?								
						<u>YES</u> <input type="checkbox"/> <u>NO</u> <input checked="" type="checkbox"/>			<u>YES</u> <input type="checkbox"/> <u>NO</u> <input checked="" type="checkbox"/>								
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 21a, PART 1 OR PART 2)											
			P.M. 19														
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>9/21</u> , 19 <u>85</u> , to <u>4/15</u> , 19 <u>86</u> , that (I) (we) last saw the deceased alive on <u>4/14</u> , 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																	
22b. SIGNATURE <u>Rita K. Shan</u>			22c. DEGREE <u>MD</u>			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22d. DATE SIGNED <u>4/15/86</u>								
22e. PHYSICIAN'S NAME (TYPE OR PRINT) <u>RITA K. SHAN</u>			22f. ADDRESS <u>14333 Laurel Bowie Rd Suit-300</u>														
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY/TOWNSHIP			23e. COUNTY STATE					
<u>Burial</u>			<u>Apr. 8, 1986</u>			<u>Mt. Olivet Cemetery</u>			<u>Washington, D.C.</u>								
24. FUNERAL DIRECTOR NAME <u>F. Gasch's Sons F.H. P.A.</u>			ADDRESS <u>Hyattsville, Maryland</u>			25a. DATE REC'D. BY REGISTRAR <u>APR 08 1986</u>			25b. REGISTRAR'S SIGNATURE <u>Johndardon Pendell</u>								

Call no. 21420

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before setting up a new population.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

80 | 2398
REG. NO.

1. FOR
STATE
REGISTRAR

1. RELEASED NAME			FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR	
(TYPE OR PRINT)			HATTIE ELIZABETH WALTERS			4/13/86			100 P.M.		
1c. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR		8. IF UNDER 24 HRS	
Female		Caucasian		Month June 13, 1896 Year		89 YRS		Months Days		Hours Min.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH		10. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)			
VIRGINIA		U.S.A.		PRINCE GEORGE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	
10. CITY OR TOWN OF DEATH		GREENBELT NURSING Home				12b. KIND OF BUSINESS OR INDUSTRY				13a. STREET ADDRESS / ZIP CODE	
GREENBELT		HOUSEWIFE				Own Home				20018	
13a. STATE		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS / ZIP CODE		14. FATHER'S NAME			
Wash. D.C.		None		Wash. D.C.		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		15. MOTHER'S MAIDEN NAME		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	
No		16b. SOCIAL SECURITY NO.		17. INFORMANT		12101 Faith Lane		16c. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Alzheimer's Disease				24 yrs.					
DUE TO, OR AS A CONSEQUENCE OF						(b)					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						(c)					
DUE TO, OR AS A CONSEQUENCE OF						(d)					
(e)						(f)					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a											
CHRONIC RENAL INSUFFICIENCY			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?					
9a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)			22a. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
21d. INJURY OCCURRED <input type="checkbox"/> NOT WHILE AT HOME <input type="checkbox"/> NOT WHILE AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
22a. I certify that (I) (we) hospital attended the deceased from March 15, 1960, to April 3, 1986, that (I) (we) lost saw the deceased alive on 3/22, 1986, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (or) view the body after death.						22c. DATE SIGNED 4-3-86.					
22b. SIGNATURE			22c. DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22d. DATE SIGNED		
James C Mandes			MD			450, Conn Ave N.W., Wash DC			APR 07 1986		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORIUM			23d. LOCATION CITY OR TOWN COUNTY STATE		
Burial			4-5-86			Fort Lincoln Cem.			Brentwood, P.G., Maryland		
24. FUNERAL DIRECTOR (NAME) FRANCIS GASCH'S SONS FUNERAL HOME, P.A. ADDRESS 4739 Baltimore Ave., Hyattsville, Md.						25a. DATE REC'D. BY REGISTRAR APR 07 1986					
25b. REGISTRAR'S SIGNATURE						25c. DATE REC'D. BY REGISTRAR					

TO HOSPITAL OR ATTENDING PHYSICIAN: After this certificate has been signed by the attending physician and certified by the hospital director, it may be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as having caused any injury, or other traumatic event, the medical examiner should be notified by the hospital or attending physician.

BP 999999

DHMH - 16 60M 7/84
(VRA 15, 4)

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2013/5/4

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2013/5/4

average speed limit 12.3 km/h

average speed limit 12.3 km/h

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. **TO FUNERAL DIRECTOR:** PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILLED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

00-0331

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 12399

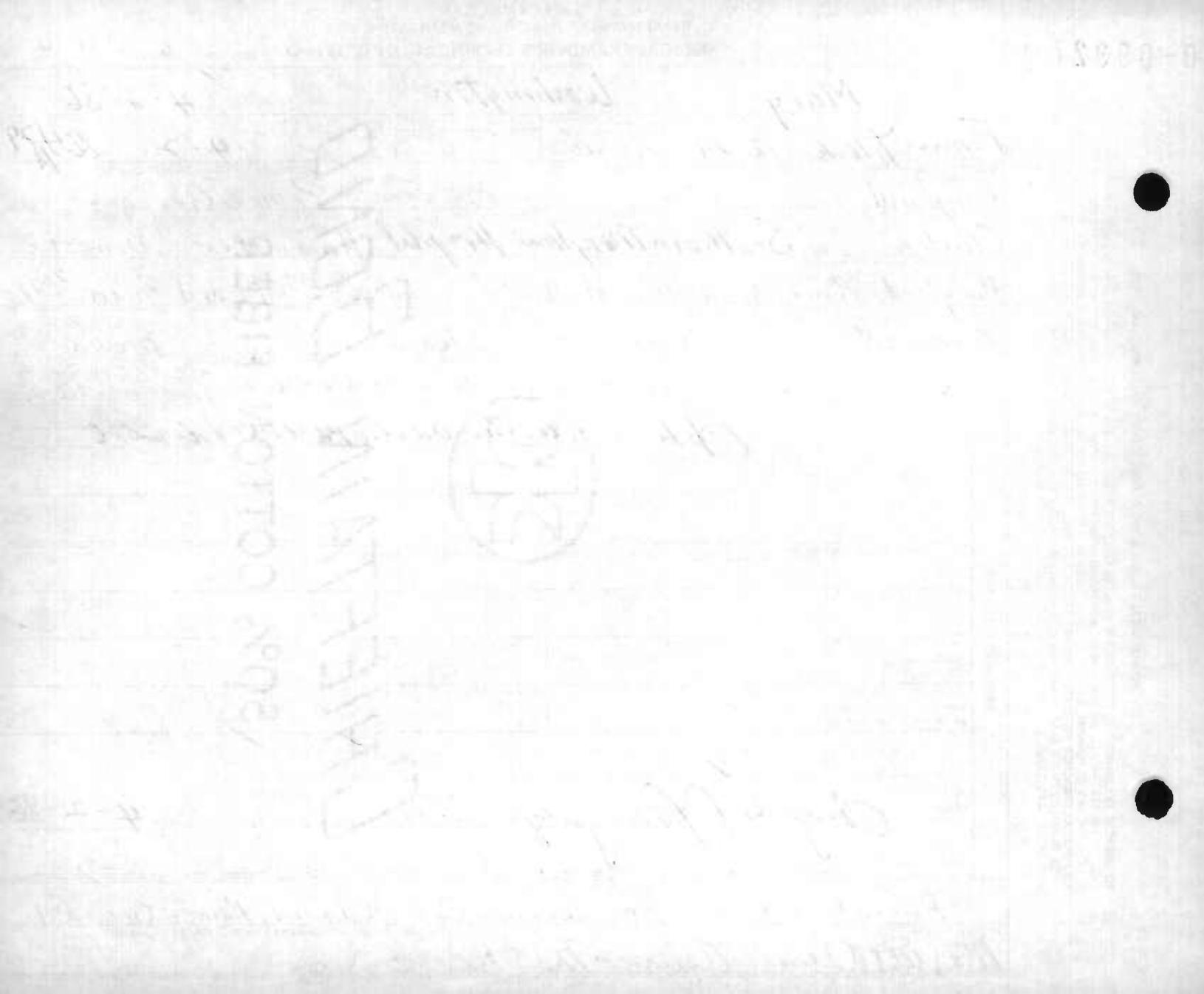
1. FOR STATE REGISTRAR		2. DATE KNOWN OF ESTI- DEATH MATED										3. MONTH DAY YEAR	
		<input checked="" type="checkbox"/> 4-8 1986										4. HOUR M	
1. DECEASED NAME (TYPE OR PRINT)		FIRST			MIDDLE		LAST			2a. DATE PRONOUNCED DEAD		2b. MONTH DAY YEAR	
<i>William Oliver Warfield</i>										4-8 1986		5. HOUR P.M.	
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN		7c. DATE PRONOUNCED DEAD	
<i>Male Black</i>				<i>JAN 26 1918 68 yrs.</i>								4-8 1986	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?										8. MARRIED WIDOWED NEVER MARRIED DIVORCED	
<i>Pennsylvania</i>		<i>United States</i>										<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
9. BALTIMORE CITY OR COUNTY OF DEATH <i>P.S.</i>													
10. CITY OR TOWN OF DEATH <i>Capitol Heights</i>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Prince George General Hospital</i>										12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Microbiologist</i>	
13a. STATE <i>MD</i>		13b. COUNTY <i>P.G.</i>		13c. CITY OR TOWN <i>Capitol Hgts</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <i>212 Hill Road 20743</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Private.</i>			
14. FATHER'S NAME FIRST		MIDDLE		LAST		15. MOTHER'S MAIDEN NAME FIRST		MIDDLE		LAST			
<i>William</i>		<i>Warfield</i>				<i>Rosa</i>		<i>Warfield</i>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <i>Unknown</i>		16b. SOCIAL SECURITY NO. <i>787-12-2988</i>		17. INFORMANT <i>Chiquita Love, 212 Hill Rd. Cap. Hgts MD.</i>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: <i>By persistent cardiovascular disease</i>		19. MEDICAL CERTIFICATION		20. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
IMMEDIATE CAUSE (a) DUE TO, OR AS A CONSEQUENCE OF		(b) DUE TO, OR AS A CONSEQUENCE OF		(c)									
Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last.													
21a. DATE OF OPERATION		21b. CONDITION FOR WHICH OPERATION WAS PERFORMED?										20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21c. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21d. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21e. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)		21f. LOCATION STREET		21g. CITY OR TOWN		21h. COUNTY		21i. STATE	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)											
22a. I certify that I took charge of the remains described above, held on <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>													
ACTUAL SIGNATURE <i>Augusto P. Rodriguez</i>		TITLE (SPECIFY) <i>Deputy</i>		M.D.		MEDICAL EXAMINER		DATE SIGNED <i>4-8-86</i>					
EXAMINER'S NAME (TYPE OR PRINT) <i>Augusto P. Rodriguez, M.D.</i>		ADDRESS 5009 Rayburn Ct., Temple Hills, MD											
23a. BURIAL, CREMATION, REMOVAL (TYPE OR PRINT) <i>Burial</i>		23b. DATE <i>4-12-86</i>		23c. NAME OF CEMETERY OR CREMATORIAL <i>Harmony Memorial</i>		23d. LOCATION CITY OR TOWN <i>Lanover Md. PG.</i>		23e. COUNTY		23f. STATE			
24. FUNERAL DIRECTOR NAME <i>Comer-Hedges 4901 Maryland Pk. Coral Hills, md.</i>		ADDRESS		25a. DATE REC'D. BY REGISTRAR <i>APR 11 1986</i>		25b. REGISTRAR'S SIGNATURE <i>-----</i>							

3. ~~Small~~ ~~Large~~

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM 3. RETAIN PAGES 1, 2, AND 3 AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE USED AS A BURIAL-CREMATION, OR REMOVAL AFTER DEATH, WITH THE STATE DIVISION OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO. 12400					
1. STATE REGISTRAR			2. DATE KNOWN OF ESTIMATED DEATH									2b HOUR					
1. DECEASED NAME (TYPE OR PRINT)			FIRST			MIDDLE			LAST			<input type="checkbox"/> MONTH <input type="checkbox"/> DAY <input type="checkbox"/> YEAR	4-2-1986				
Mary									Washington			<input type="checkbox"/> MONTH <input type="checkbox"/> DAY <input type="checkbox"/> YEAR	4-2-1986				
3. SEX Female			4. DATE OF BIRTH MONTH DAY YEAR			5. AGE (IN YEARS LAST BIRTHDAY)			6. IF UNDER 1 YR. MONTHS DAYS			7. IF UNDER 24 HRS. HOURS MIN					
Stock			12 24 45			40 yrs.											
8. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?									8. MARRIED WIDOWED			9. PRONOUNCED DEAD		
Maryland			USA									<input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED			4-2-1986		
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN HOSPITAL FACILITY, GIVE ADDRESS)									12. USUAL OCCUPATION (TYPE OF WORK) (LIST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY		
Clinton			Southern Maryland Hospital									Homemaker			Domestic		
13. STATE Maryland			13a. COUNTY Prince Georges			13c. CITY OR TOWN Upper Marlboro			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS 3652 Tanward Road			20772		
14. FATHER'S NAME Frederick			MIDDLE			LAST			15. MOTHER'S MAIDEN NAME Eleanora			BROWN			LAST		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)			16b. SOCIAL SECURITY NO. 213-46-9117									17. INFORMANT Eleanora Makie Brandywine, Md. 20613			ADDRESS Rte 1 Box 240A		
NO			N/a														
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)													APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1.																	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?									20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY STATE					
22. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																	
ACTUAL SIGNATURE		TITLE (SPECIFY) Augusto P. Rodriguez, M.D. Deputy MEDICAL EXAMINER											DATE SIGNED 4-2-86				
EXAMINER'S NAME (TYPE OR PRINT)			ADDRESS 5009 Rayburn Ct, Temple Hills, MD														
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN			23e. COUNTY STATE					
Burial			7 APRIL '86			RESURRECTION Cem			Clinton, Prince Geo, Md								
24. FUNERAL DIRECTOR NAME			ADDRESS									25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE		
Markell Adams			Aquasco Md 20608									APR 11 1986			11-11-86		

3929-6



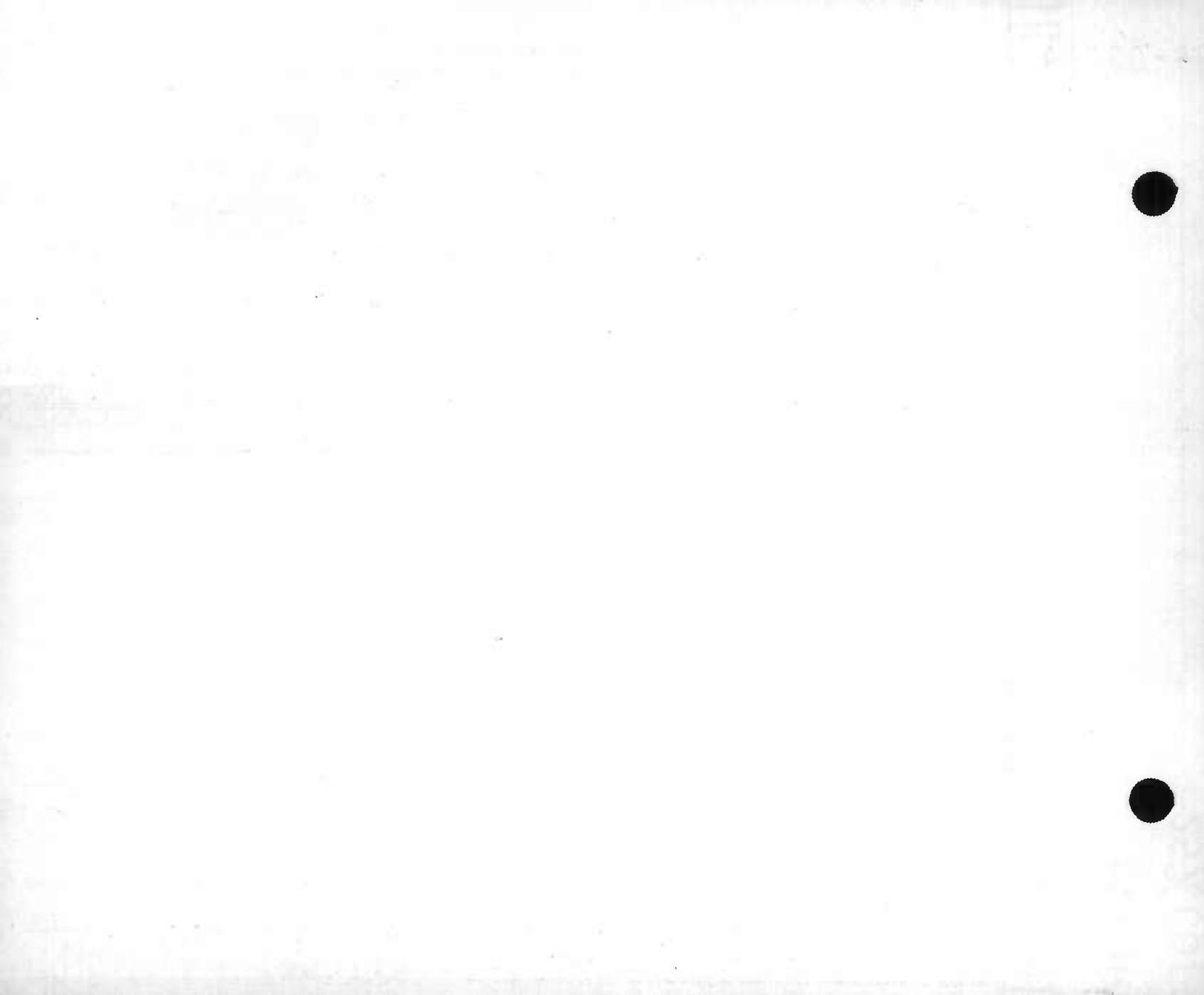
HOSPITAL ATTENDING PHYSICIAN The law requires that the death certificate be executed within 24 hours after death. Page 4 may be

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

6 12401
REG. NO.

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Glenn GLENN MELVIN WEES				FIRST MIDDLE LAST	2a. DATE OF DEATH MONTH DAY YEAR Apr. 8 APR 08, 1986 1986	2b. HOUR 11:00a.m.
3 SEX Male	4 RACE Caucasian	5. DATE OF BIRTH MONTH DAY YEAR JUN 06, 19 DAY 1/6/22	6. AGE (IN YEARS LAST BIRTHDAY) 64	7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) West Virginia		7b. CITIZEN OF WHAT COUNTRY? U.S.A.	MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. COUNTY OF DEATH Prince George's County MD		
10. CITY OR TOWN OF DEATH Cheverly		11. NAME OF FACILITY (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Prince George's General Hospital	12. HER INSTITUTION Brick Layer	12b. KIND OF BUSINESS OR INDUSTRY Construction		
13a. STATE Maryland		13b. COUNTY P.G.	13c. CITY OR TOWN Forestville	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS 6569 Hillmar Drive, Apt. #202	
14. FATHER'S NAME FIRST Bernard		MIDDLE Weese	15. MOTHER'S NAME FIRST Mary	MIDDLE Crates	LAST	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes-Navy		16b. SOCIAL SECURITY NO. W.W.II 232-26-7298	17. INFORMANT Helen J. Weese (Wife)	18. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Massive Cerebral Infarct						
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____						
DUE TO, OR AS A CONSEQUENCE OF (c) _____						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) S/P CABG, S/P AVR, S/P Squam Cell Ca, S/P Bladder Ca.						
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) 84		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	21g. DATE SIGNED 4/8/86		
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 84 , 19 84 , to 418 , 19 86 , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we did) <input type="checkbox"/> (did not) view the body after death.						
22b. SIGNATURE Stuart Turley Jr.						
22c. PHYSICIAN'S NAME (TYPE OR PRINT) Stuart Turley Jr.		22d. DEGREE M.D.	22e. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22f. DATE SIGNED 4/8/86		
22g. ADDRESS 8500 Greencastle Dr. Greenebelt Md. 20770						
22h. BURIAL CREMATION REMOVAL Burial		22i. DATE 04/10/86	22j. NAME OF CEMETERY OR CREMATORIAL Md. Veterans Cemetery	22k. LOC. CITY OR TOWN Cheltenham P.G. Maryland	22l. DATE REC'D. BY REGISTRAR APR 11 1986	
24. FUNERAL DIRECTOR Francis Gasch's Sons Funeral Home, P.A. 4739 Baltimore Avenue Hyattsville, Md. 20781		22m. REGISTRAR'S SIGNATURE John Anderson				



0-04742

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove signature from page 3. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 8012402				
1 - STATE REGISTRAR			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR								
1. DECEASED NAME (TYPE OR PRINT) Catherine B Wheeler			MIDDLE LAST			April 21 1986			2:50AM					
3. SEX Female			4. RACE White			5. DATE OF BIRTH MONTH DAY YEAR Feb 5, 1916			6. AGE (IN YEARS LAST BIRTHDAY) 70 yrs.	IF UNDER 1 YEAR MONTHS 0	IF UNDER 24 HRS HOURS 0	MIN. 0		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington DC			7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Prince George					
10. CITY OR TOWN OF DEATH Silver Hill			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 3528 Terrace Drive Apt C			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired			12b. KIND OF BUSINESS OR INDUSTRY PG Schoolsyst					
13a. STATE Maryland			13b. COUNTY PR Geo			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			14. FATHER'S NAME FIRST MIDDLE LAST Joel G Bodine			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Rose A Hagan		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 579-16-4176			17. INFORMANT William H Raff/son			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory Arrest DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)			ADDRESS 2111 S Heather Lane Gambrills, Md		
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE								
22a. I certify that (I) (this hospital) attended the deceased from February 19 86 , to Oct 15 75 , saw the deceased live on above, (I) (we) (did) (did not) view the body after death.						22b. DATE SIGNED Apr 21 86								
22b. SIGNATURE Catherine Wheeler						22c. DEGREE MD								
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Mark H Pillor M D			22e. ADDRESS 6188 Oxon Hill Rd Oxon Hill Md											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 23 Apr 1986			23c. NAME OF CEMETERY OR CREMATORIUM Fort Lincoln Cemetery			23d. LOCATION CITY OR TOWN COUNTY STATE Brentwood PG Md					
24. FUNERAL DIRECTOR NAME Robert E Wilhelm			ADDRESS Suitland, Md.			25a. DATE REC'D. BY REGISTRAR APR 24 1986			25b. REGISTRAR'S SIGNATURE Jeanne Johnson-Pondress					

CASE 0-0

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8612403
REG. NO.

1 - STATE
REGISTRAR

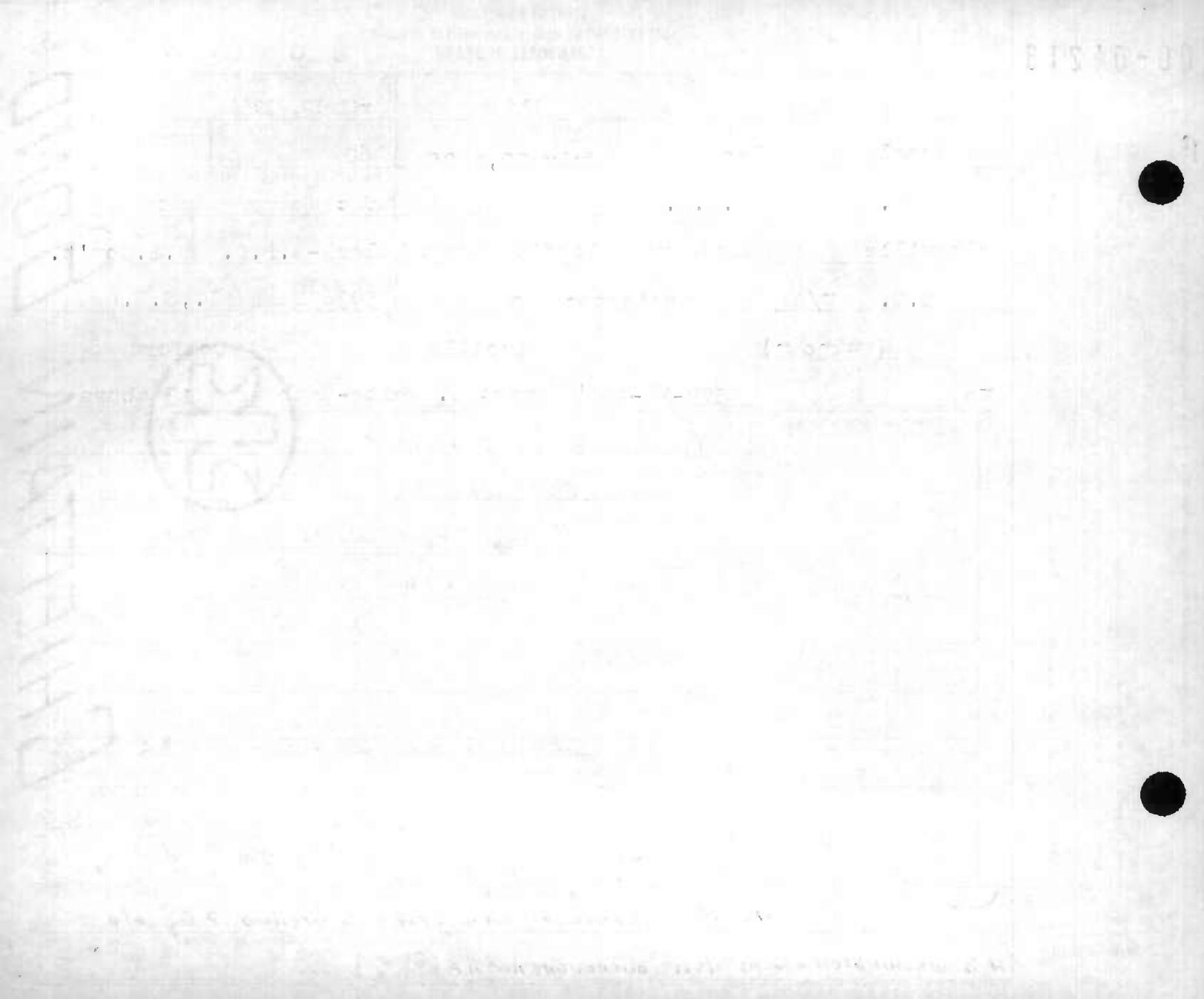
1. DECEASED NAME (TYPE OR PRINT)				FIRST / MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR	
Adele				D	White	April 10, 1986			7:58P M		
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS.	
Female		Black		July 22, 1925		60		YRS		MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
Va.		U.S.A.				Prince Georges County MD.					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)						12b. KIND OF BUSINESS OR INDUSTRY	
Beltsville		Greater Laurel Beltsville Hospital		Clerk-G.P.O.						U.S. Gov't.	
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS / ZIP CODE		99999	
D.C.		N/A		Washington		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		5436 Bass Pl., S.E.			
14. FATHER'S NAME		FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME						
		(Unknown)			Lucille						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT						ADDRESS	
No		579-24-1694		Mason W. White-Same as # 13 above							
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
<p>18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY:</p> <p>IMMEDIATE CAUSE (a) <u>Cardiopulmonary Arrest</u></p> <p>DUE TO, OR AS A CONSEQUENCE OF (b) <u>Coma</u></p> <p>DUE TO, OR AS A CONSEQUENCE OF (c) <u>CEREBROVASCULAR ACCIDENT</u></p>											
<p>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a</p> <p><u>Diabetes Mellitus; Hypertension, Renal Failure</u></p>											
19a. MEDICAL CERTIFICATION		19b. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
						YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED <input type="checkbox"/> WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE	
<p>22a. I certify that (I) (this hospital) attended the deceased from <u>4-1-1986</u> to <u>4-10-1986</u>, that (I) (we) last saw the deceased alive on <u>4-10-1986</u>, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.</p>											
22b. SIGNATURE		<u>G. M. DIN, M.D.</u>		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS		<u>6510 Kanawha Ave</u>					
						<u>Riverdale St. D. 20737</u>					
23a. BURIAL, CREMATION, REMOVAL		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL		23d. LOCATION CITY OR TOWN		COUNTY		STATE	
		4-15-86		LINCOLN MEM. CEM.		SUITLAND, P.G., MD.					
24. FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR		26b. REGISTRAR'S SIGNATURE					
H. S. WASHINGTON & SONS		4925 BURRINGTON AVE., N.E.		APR 21 1986							

99999999
0 HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be

Q. FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial permit permit. Then please remove carbon copies. Pages 1 and 2 should be filed with a 72 hour death certificate in the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked off item 18 showing injury, or other traumatic event, in medical section, the medical examiner will be notified of same.

BP _____
DIAMH - 16 60M 7/84
(VRA 15, 4)



0 - 03926

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be detached from the burial/transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal with the medical examiner if item 18 shows any injury, or other traumatic event, the medical examiner should be notified.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8	6	1	2	4	0	4					
												REG. NO. 12404											
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR											
Esther			M	Whitman		April 10, 1986						7:35 P.M.											
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR			IF UNDER 24 HRS										
female		white		MONTH March 18 DAY 1902 YEAR			84			YRS.			MONTHS DAYS HOURS MIN.										
7a. BIRTHPLACE COUNTRY		7b. CITIZEN OF WHAT COUNTRY?		8			MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.										
Maryland		USA								Prince Georges County													
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY																
Laurel		Greater Laurel Beltsville Hospital		housewife			home																
13a. STATE Maryland												13b. COUNTY P.G.			13c. CITY OR TOWN Laurel			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE 711 park ave 20707		
14. FATHER'S NAME FIRST			MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST			MIDDLE	LAST														
Henry				Whitehead	Mabel					Marks													
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT			ADDRESS																
no		579 64 7614		Barbara Nichols			401 6th street laurel, Md																
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH monthly											
DUE TO, OR AS A CONSEQUENCE OF (b) <i>Arteriosclerosis</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.												year											
DUE TO, OR AS A CONSEQUENCE OF (c) <i>Heart Failure</i>																							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>Hypertension</i> <i>Left leg</i> <i>2) Pseudomonas</i> <i>Urinary infection</i>																							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?															
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) saw the deceased alive on 4/10 1986			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>												
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY STATE												
22a. I certify that (I) (the hospital) attended the deceased from August 19, 81 to 4/10 1986, that (I) <input checked="" type="checkbox"/> lost saw the deceased alive on 4/10 1986, and that in (my) <input checked="" type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above, (I) <input checked="" type="checkbox"/> did not view the body after death.												22c. DATE SIGNED 4/11/86											
22b. SIGNATURE <i>Dennis L Schubert MD</i>												DEGREE MR											
22c. PHYSICIAN'S NAME (TYPE OR PRINT) Dennis L Schubert MD												ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>											
23a. BURIAL, CREMATION, REMOVAL SPECIFY		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIUM			23d. LOCATION CITY OR TOWN			23e. DATE REC'D. BY REGISTRAR			23f. REGISTRAR'S SIGNATURE										
burial		April 14, 1986		Ivy Hill Cemetery			Laurel			P.G.			Maryland										
24. FUNERAL DIRECTOR NAME Donaldson Funeral Home P.A. Laurel, Maryland												APR 16 1986			Julia L. Donaldson								
BP _____																							
DHMH - 16 60M 7/84 (VRA 15, 4)																							

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UNIVERSITY OF TORONTO LIBRARIES



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please have it carbon copied. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 22 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 8012405			
1. DECEASED NAME (TYPE OR PRINT)			FIRST Albert	MIDDLE Lee	LAST WHITMORE			2a. DATE OF DEATH April 17, 1986			MONTH YEAR	2b. HOUR 4:50 a.m.	
3. SEX male		4. RACE white		5. DATE OF BIRTH MONTH DAY YEAR Jan 13 1910			6. AGE (IN YEARS LAST BIRTHDAY) 76 YRS.			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN			
7a. BIRTHPLACE COUNTRY Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's County, MD.						
10. CITY OR TOWN OF DEATH Lanham		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) AMI/Doctors' Hospital of PG County		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) supervisor			12b. KIND OF BUSINESS OR INDUSTRY WSSC						
13a. STATE Maryland		13b. COUNTY P.G.		13c. CITY OR TOWN Adelphi			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE 9204 25th Place 20783			
14. FATHER'S NAME Charles		MIDDLE	Whitmore		15. MOTHER'S MAIDEN NAME Minnie			MIDDLE	Rutledge				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. WW II		16c. INFORMANT Ellena Lee Knox			ADDRESS 1437 Jerald Place, Crofton, Md			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 days			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiopulmonary failure</u>													
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Coronary Heart Disease, myocardial Infarction</u>													
DUE TO, OR AS A CONSEQUENCE OF (c) <u>Ventricular tachycardia, Left bundle Branch Block</u>													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>Chronic obstructive pulmonary Disease. Electrolyte imbalance.</u>													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN	COUNTY	STATE			
22a. I certify that (I) (this hospital) attended the deceased from April 15, 1986, to April 17, 1986, that (I) (we) last saw the deceased alive on April 17, 1986, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE <u>CHIN-CHUAN HSU</u>		22c. DEGREE M.D.			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22d. DATE SIGNED					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>CHIN-CHUAN HSU</u>		22e. ADDRESS 6419 Baltimore Ave Riverdale Maryland 20737											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) burial		23b. DATE 4-19-1986		23c. NAME OF CEMETERY OR CREMATORIAL Monticello Mem. Gardens			23d. LOCATION CITY OR TOWN Charlottesville			COUNTY	STATE Va		
24. FUNERAL DIRECTOR NAME Donaldson Funeral Home P.A.		ADDRESS Laurel, Maryland			25a. DATE REC'D. BY REGISTRAR APR 22 1986			25b. REGISTRAR'S SIGNATURE John					

8



TO HOSPITAL OR ATTENDING PHYSICIAN: The [REDACTED] reigned by the hospital or attending physician

Death certificate to be executed within 24 hours after death. Page 4 may be

BURIAL CERTIFICATE. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove bumper. Pages 1 and 2 should be buried with the deceased after death with the State Dept. of Health and Mental Hygiene prior to burial or cremation.

MEDICAL CERTIFICATION

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1 - FOR
STATE
REGISTRATION

I. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR	
RUTH E WIEGAND						APR	15	86		2:10pm	
3. SEX	4. RACE		5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)					
Female	White		NOV 21, 1914			71	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA			8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince George MD.				
10. CITY OR TOWN OF DEATH AAFB		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SAME FACILITY, GIVE STREET ADDRESS) Malcolm Grow Medical Center			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HomeMaker			12b. KIND OF BUSINESS OR INDUSTRY Own Home			
13a. STATE Virginia		13b. COUNTY Fairfax		13c. CITY OR TOWN Herndon	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 899 Park Avenue #101		99999		
14. FATHER'S NAME FIRST Raymond		MIDDLE H	LAST Shegogue	15. MOTHER'S MAIDEN NAME Sr Ruby		MIDDLE		LAST Kerr			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) --			16c. INFORMANT Gail Wiegand		ADDRESS Same as #13				
18. CAUSE OF DEATH (Enter only one cause per line for each part.) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		CARDIOPULMONARY ARREST <i>Cardiorespiratory Arrest</i>						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH -			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		DUE TO, OR AS A RESULT OF CEREBROVASCULAR ACCIDENT <i>Cerebrovascular Accident</i>						72h			
{ (b) _____ (c) _____		DUE TO, OR AS A CONSEQUENCE OF _____									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b PART 1 or PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY	STATE
22a. I certify that (I) (this hospital) attended the deceased from 12 Apr 86, 19 86, to 15 Apr 86, 19 86, that (I) (we) last saw the deceased alive on 15 Apr 86, 19 86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <i>Michael J. Costello</i>		22c. DEGREE B.A.			ATTENDING PHYSICIAN <input type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF <input type="checkbox"/> PHYSICIAN <input checked="" type="checkbox"/>			22d. DATE SIGNED 15 Apr 86			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS AAFB Maryland									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 21 Apr 1986		23c. NAME OF CEMETERY OR CREMATORIAL Arlington National		23d. LOCATION CITY OR TOWN Arlington		COUNTY			STATE Va.
24. FUNERAL DIRECTOR NAME Robert E. Wilhelm Funeral Home		ADDRESS Suitland, MD.			25a. DATE REC'D. BY REGISTRAR APR 22 1986		25b. REGISTRAR'S SIGNATURE <i>John Davidson -</i>				

16840-0

DOUGLASS

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked as Item 18 shows any injury, or other traumatic event, the medical certification section must be completed.

MEDICAL CERTIFICATION

1 - FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8612401
REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR	
Myrtle			M.		Williams	4	24	86	8 A.M.		
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS	
Female		White		MONTH	DAY	YEAR	66	MONTHS	DAYS	HOURS	MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince Georges MD.					
New York		U.S.A.									
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY	
Acookeek		18310 Indian Head Hwy.				Telephone Oper.				U. of Md.	
13a. STATE Md.		13b. COUNTY P.G.		13c. CITY OR TOWN Acookeek		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 18310 Indian Head Hwy. 20607			
14. FATHER'S NAME FIRST Fred		MIDDLE		LAST Arkills		15. MOTHER'S MAIDEN NAME FIRST Bertha		MIDDLE		LAST McClure	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 062-14-9413		17. INFORMANT William J. Williams as in item 13		ADDRESS					
18. CAUSE OF DEATH (Enter only one cause per line for 18a, 18b, and 18c) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 6 hours											
DUE TO, OR AS A CONSEQUENCE OF (b) Coronary Artery Disease											
DUE TO, OR AS A CONSEQUENCE OF (c) _____											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 18a Diabetes Mellitus											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) 4116		21f. LOCATION STREET 8113		CITY OR TOWN 4114		COUNTY		STATE	
22a. I certify that (I) (this hospital) attended the deceased from 4/16 19 86 , to 4/14 19 86 , that (I) (we) last saw the deceased alive on 4/16 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (I) (did not) view the body after death.											
22b. SIGNATURE Robert A. Vigerstky		DEGREE M.D.		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 4/24/86					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Robert A. Vigerstky, M.D.		22e. ADDRESS 5711 Allentown Road, Suitland, MD									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 4-28-86		23c. NAME OF CEMETERY OR CREMATORIAL Ft. Lincoln Cemetery		23d. LOCATION CITY OR TOWN Brentwood		COUNTY P.G.		STATE Md.	
24. FUNERAL DIRECTOR NAME G.P. Kalas F.H.		ADDRESS 6160 Oxon Hill Rd. Oxon Hill, Md.		25a. DATE REC'D. BY REGISTRAR APR 28 1986		25b. REGISTRAR'S SIGNATURE Julie Deirdre Pendleton					

Planned by Dr. J. H. F. Bridges

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified of same.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
REG. NO. 2 0 8 AL 11:40am											
1. FOR STATE REGISTRAR			1. DECEASED NAME (TYPE OR PRINT)			LAST			2a. DATE OF DEATH		
			SADIE GOLTHAN WILLIAMS			WILLIAMS			MONTH DAY YEAR		
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)		
Female			Black			MONTH DAY YEAR			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8			9. BALTIMORE CITY OR COUNTY OF DEATH		
South Carolina			United States			MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			PRINCE GEORGES CO., MD		
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY		
CLINTON			St. MARYLAND Hospital			Homemaker			Domestic		
13a. STATE			13b. COUNTY			13d. INSIDE CITY LIMITS?			13e. STREET ADDRESS / ZIP CODE		
Maryland			Prince Georges			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			12317 Livingston Road 20744		
14. FATHER'S NAME			LAST			15. MOTHER'S MAIDEN NAME					
FIRST Lacey			Golthan			FIRST Lula			MIDDLE Ingram		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)			17. INFORMANT			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
No			577-84-2375			709 Kentucky Avenue, S.E.; (20003) Junious & Edna B. Wooten (friends) Wash. DC					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Septic Shock.											
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b)											
DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. Atherosclerotic Heart Disease											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART 1 OR PART 2)			YES <input type="checkbox"/> NO <input type="checkbox"/>		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 4/22/86, 19, to 4/22, 19, 86, that (I) (we) last saw the deceased alive on 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <i>Mehrdad Mostaan</i>			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 4/23/86		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Mehrdad Mostaan, M.D.			22e. ADDRESS 4235 28th Ave., Temple Hills, MD						20748		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 04/26/86			23c. NAME OF CEMETERY OR CREMATORIAL Lincoln Memorial Cem.			23d. LOCATION CITY OR TOWN Suitland, P.G.C., Maryland COUNTY STATE		
24. FUNERAL DIRECTOR NAME LATNEY'S Funeral Home ADDRESS 3831 Georgia Avenue, NW; Washington, DC 20011						25. DATE REC'D. BY REGISTRAR MAY 2 1986 <i>J. H. F. Bridges</i>					

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

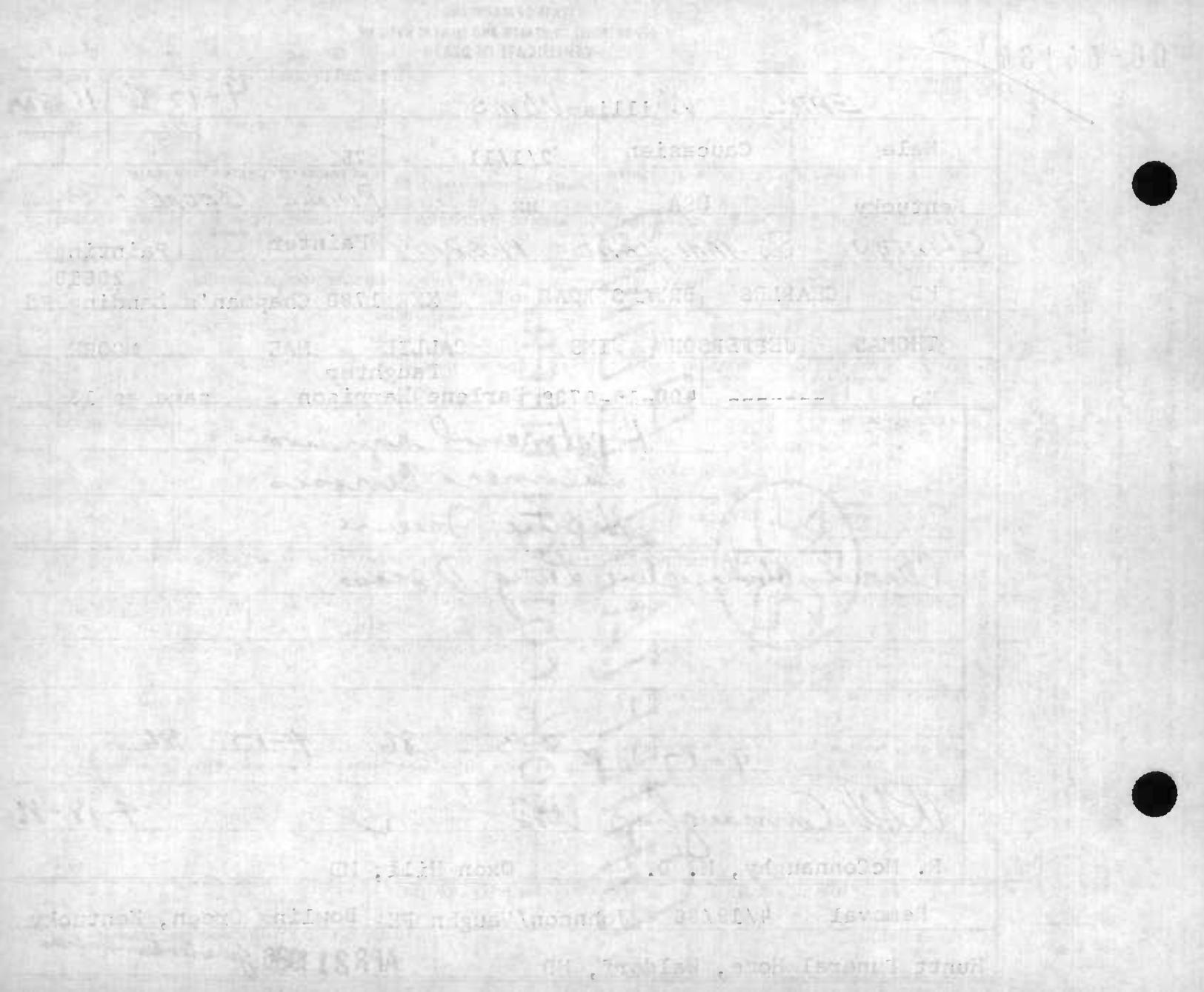
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be detached for use on the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, a medical examination should be made.

FOR
1 - STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH8612409
REG. NO.

00-04164

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR	
<i>EARL W. Wims</i>						4-17-86				1138AM	
1c. SEX			4. RACE	5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)			7b. HOUR		
Male			Caucasian	2/1/11		75 YRS.			IF UNDER 24 HRS MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH				
Kentucky			USA				PRINCE GEORGES Co. MD				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY				
Clinton			So. Maryland Hospital		Painter		Painting				
13a. STATE			13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE			20616	
MD			CHARLES	BRYANS ROAD			1780 Chapman's Landing Rd				
14. FATHER'S NAME FIRST			MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST		MIDDLE	LAST			
THOMAS			JEFFERSON	WIMS	CALLIE		MAE	MOORE			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT		Daughter				
No			400-16-0739		Earlene Harrison		same as 13				
18. CAUSE OF DEATH (Enter only one cause per line for 1a, b, and c) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)			Hepatorenal syndrome						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last			(b) Jaunee Cirrosis								
			(c) Hepatic Failure								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)						Chronic Obstructive Lung Disease					
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
						YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY	STATE	
22a. I certify that (I) (this hospital) attended the deceased from 4-17-86 to 4-17-86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death											
22b. SIGNATURE			DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED				
R. McConaughy, M.D.							7-18-86				
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS								
R. McConaughy, M.D.			Oxon Hill, MD								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN			
Removal			4/19/86		Johnson/Vaughn FH			Bowling Green, Kentucky			
24. FUNERAL DIRECTOR NAME			ADDRESS		25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE			
Huntt Funeral Home, Waldorf, MD					APR 21 1986			Julie Dawson-Gendell			



TO HOSPITAL OR ATTENDING PHYSICIAN: The retained by the hospital or attending physician

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove all papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove the papers. Page 1 and 2 should be filed within 72 hours after death.

IMPORTANT: If Item 2 is marked or Item 18 shows any injury, or other traumatic event, the medical facilitator must be notified at once with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

EXAMINER NOTIFIED

MEDICAL CERTIFICATION

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 | 2 4 | 0
REG. NO.

DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	DATE OF DEATH	MONTH	DAY	YEAR	2b HOUR
Calvert Lee Windsor						April 25 1986				7:30 M
1. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH YEAR Mar 23 1927	6. AGE (IN YEARS LAST BIRTHDAY) 59	IF UNDER 1 YEAR MONTHS YRS	IF UNDER 24 HRS HOURS MIN.					
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Prince George							
10. CITY OR TOWN OF DEATH Up Marlboro	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION IF PERTAINING SUCH FACILITY, GIVE STREET ADDRESS 3308 Ritchie Marlboro Road	12a. USUAL OCCUPATION Mgr Flower Shop			12b. KIND OF BUSINESS OR TRADE WORKED MOST OF WORK TIME INDUSTRY Retail 20772					
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13. STATE Maryland	13. COUNTY Pr Geo	13. CITY OR TOWN Up Marlboro	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 3308 Ritchie Marlboro Road						
14. FATHER'S NAME FIRST Calvert	MIDDLE Windsor	LAST Catherine	15. MOTHER'S MAIDEN NAME FIRST Brady							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES OR UNKNOWN) Yes	16b. SOCIAL SECURITY NO. (IF UNKNOWN, GIVE DATE OR DATES) WWII	16c. INFORMANT Mary M Windsor	ADDRESS Same as #13							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)			Respiratory Failure Metastatic Cancer Castriz Cervicant			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3days 8 month				
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a Metastatic Colon Cancer										
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET	CITY OR TOWN	COUNTY	STATE					
22a. I certify that (I) (This hospital) attended the deceased from saw the deceased alive on 10 Nov 85 , to 25 April 86 , that in my (our) opinion death occurred on the date and hour and from the causes stated above (I/we) did (did not) view the body after death.	15 Nov 85 to 25 April 86									
22b. SIGNATURE Thomas A. Beusinger	DEGREE MD	ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED 4/26/86							
22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 30 Apr 86	23c. NAME OF CEMETERY OR CREMATORIAL Maryland Veterans	23d. LOCATION CITY OR TOWN Cheltenham	23e. COUNT Maryland	23f. DATE REC'D. BY REGISTRAR APR 30 1986					
24. FUNERAL DIRECTOR NAME Robert E Wilhelm Funeral Home	ADDRESS Suitland Maryland	25. REGISTRAR'S SIGNATURE Julia Windsor-Pondell								

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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												86124	REG. NO.	
1- STATE REGISTRAR		FIRST MYRTLE			MIDDLE V.	LAST WINDSOR			2d. DATE OF DEATH	MONTH 04	DAY 24	YEAR 86	2d. HOUR 5 10PM	
1. DECEASED NAME (TYPE OR PRINT)		3. SEX Female			4. RACE White	5. DATE OF BIRTH October 11 1897			6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR MONTHS 88 YRS		IF UNDER 24 HRS MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGE'S COUNTY MD.						
10. CITY OR TOWN OF DEATH CHEVERLY		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker			12b. KIND OF BUSINESS OR INDUSTRY Own Home						
13a. STATE Maryland		13b. COUNTY PG			13c. CITY OR TOWN Landover			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>					13e. STREET ADDRESS / ZIP CODE 9800 Lottsford Road 20785	
14. FATHER'S NAME George		MIDDLE W.	LAST Windsor			15. MOTHER'S MAIDEN NAME Mary Alice Peacock								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 216 40 5334			17. INFORMANT George A Windsor Same as #13									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Inferior Myocardial Defaction</i>												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause, if any.												<i>Arteriosclerotic Cardiovascular Disease</i>		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>Hypertension</i>														
19a. DATE OF OPERATION <i>9/9/86</i>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY	STATE			
22a. I certify that (I) (this hospital) attended the deceased from <i>Aug 1986</i> to <i>Apr 1986</i> , and that in (my) (<i>not</i>) opinion death occurred on the date and hour and from the causes stated saw the deceased alive on <i>Aug 1986</i> and that in (my) (<i>not</i>) view the body after death												22c. DATE SIGNED <i>4/24/86</i>		
22b. SIGNATURE <i>W.H. Holmes, M.D.</i>		22e. DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>									
22d. PHYSICIAN'S NAME (TYPE OR PRINT) A/C. HOLMES, MD		22e. ADDRESS 14314 OLD MARLBORO PIKE UP MARLBORO, MD 20870												
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 29 April 1885			23c. NAME OF CEMETERY OR CREMATORIAL Epiphany Church Cem			23d. LOCATION CITY OR TOWN Forestville COUNTY Maryland STATE						
24. FUNERAL DIRECTOR NAME Robert E Wilhelm Funeral Home Suitland Maryland								25a. DATE REC'D. BY REGISTRAR 12230 1096					25b. REGISTRAR'S SIGNATURE <i>J. K. Kuhn</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN, 110 W. PRESTON ST., BALTIMORE, MARYLAND 21201
retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 2 and 3 should be filed within 24 hours after death. Page 4 may be filed within 72 hours after death.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be submitted within 24 hours after death. Page 4 may be referred by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be detached for use as the burial-troupe permit. Then please remove carbon paper. Please mail or file within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 18 is marked or item 19 is checked, the medical examiner will be notified.

00-04974
 DECEASED NAME: LOUIS ROBERT WINEMILLER
 3. SEX: Male RACE: White
 7a. BIRTHPLACE: Washington, D.C.
 10 CITY OR TOWN OF DEATH: Lanham
 13a STATE: Maryland 13b COUNTY: P.G.
 14 FATHER'S NAME: Clarence M. Winemiller
 16a WAS DECEASED EVER IN U.S. ARMED FORCES? No
 18 CAUSE OF DEATH: Bladder Cancer with
 IMMEDIATE CAUSE (a) Due to, or as a consequence of
 (b) Due to, or as a consequence of
 (c) Due to, or as a consequence of
 PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a
 19a DATE OF OPERATION
 19b CONDITION FOR WHICH OPERATION WAS PERFORMED
 20a AUTOPSY? YES NO
 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES NO
 21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH
 (IF EITHER NOTIFY MEDICAL EXAMINER)
 21d. INJURY OCCURRED
 WHILE AT WORK NOT WHILE AT WORK
 22a. I certify that (I) (this hospital) attended the deceased from 3-12, 1986, to 4-24, 1986, that (I) (we) last saw the deceased on 4-24, 1986, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (not) (see) the body after death.
 22b. SIGNATURE: Asif Qadri, M.D.
 22c. DATE SIGNED: 4-24-86
 22d. PHYSICIAN'S NAME: Asif Qadri, M.D.
 22e. ADDRESS: 4713 Berwyn Road College Park, Maryland 20740
 23a. BURIAL, CREMATION, REMOVAL
 (SPECIFY) Cremation
 23b. DATE: 4/28/86
 23c. NAME OF CEMETERY OR CREMATORIAL: Metropolitan Crematory
 23d. LOCATION: Alexandria N/A Virginia
 24. FUNERAL DIRECTOR
 NAME: Francis Gasch's Sons Funeral Home, P.A.
 ADDRESS: 4739 Baltimore Avenue Hyattsville, Md. 20781
 25a. DATE REC'D. BY REGISTRAR: APR 28 1986
 25b. REGISTRAR'S SIGNATURE: John [Signature]

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH
 8612412
 REG. NO.
 2a. DATE OF DEATH: April 24, 1986
 2b. HOUR: 3:06 AM
 6. AGE (IN YEARS LAST BIRTHDAY): 82
 IF UNDER 1 YEAR
 MONTHS DAYS HOURS MIN.
 9. BALTIMORE CITY OR COUNTY OF DEATH: Prince George's County MD.
 12a. USUAL OCCUPATION: Partner
 12b. KIND OF BUSINESS OR INDUSTRY: Hyattsville Buick
 13d. INSIDE CITY LIMITS? YES NO
 13e. STREET ADDRESS / ZIP CODE: 3903 Commander Drive 20782
 15. MOTHER'S MAIDEN NAME: Mittie E.
 17. INFORMANT: Rhoda H. Winemiller (Wife) Same as #13
 APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
 18. CAUSE OF DEATH: Bladder Cancer with
 PART I. DEATH WAS CAUSED BY:
 IMMEDIATE CAUSE (a) Due to, or as a consequence of
 (b) Due to, or as a consequence of
 (c) Due to, or as a consequence of
 20. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
 YES NO
 21. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
 YES NO
 22. DATE OF OPERATION
 23. CONDITION FOR WHICH OPERATION WAS PERFORMED
 24. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)
 25. TIME OF INJURY
 HOUR A.M. MONTH DAY YEAR
 P.M. 19
 26. PLACE OF INJURY
 (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)
 27. LOCATION
 STREET CITY OR TOWN COUNTY STATE
 28. ATTENDING PHYSICIAN
 MEDICAL DIRECTOR STAFF PHYSICIAN
 29. ADDRESS
 30. DATE SIGNED
 31. PHYSICIAN'S NAME
 32. ADDRESS
 33. BURIAL, CREMATION, REMOVAL
 (SPECIFY) Cremation
 34. DATE: 4/28/86
 35. NAME OF CEMETERY OR CREMATORIAL: Metropolitan Crematory
 36. LOCATION: Alexandria N/A Virginia
 37. FUNERAL DIRECTOR
 NAME: Francis Gasch's Sons Funeral Home, P.A.
 ADDRESS: 4739 Baltimore Avenue Hyattsville, Md. 20781
 38. DATE REC'D. BY REGISTRAR: APR 28 1986
 39. REGISTRAR'S SIGNATURE: John [Signature]

17810-00



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B, GIVE PAGE 1 AND 2 TO THE FUNERAL DIRECTOR, PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM FM-3 RETAIN PAGE 5 FOR YOUR FILES. **TO FUNERAL DIRECTOR:** PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRINSTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 2413

I. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST			
Alex			Winstead Jr			2a DATE KNOWN <input checked="" type="checkbox"/> MONTH DAY YEAR		
3. SEX	4 RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY) YRS.	7. IF UNDER 1 YR. MONTHS DAYS	8. IF UNDER 24 HRS. HOURS MIN.	DEATH MATED <input type="checkbox"/> 4/ 26/19 86		
Male	Black	Jan. 07, 1946	40			2b HOUR 24 HOUR 10:2		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) North Carolina		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's County, MD		
10. CITY OR TOWN OF DEATH Capital Heights		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 6907 Central Ave.			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Labor		12b. KIND OF BUSINESS OR INDUSTRY Construction	
13a. STATE Maryland		13b. COUNTY U. S. A.	13c. CITY OR TOWN Landover	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 6907 Central Avenue 20785		
14. FATHER'S NAME FIRST MIDDLE LAST Alex Winstead, Sr.			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mavin Feathstone					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No			16b. SOCIAL SECURITY NO. 241-78-4485			17. INFORMANT Elzenie Wright 6907 Central Ave. Cap. Hgt		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Ethanolism</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)								
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH								
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). <u>Hypertrophic Cardiomyopathy</u>								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21a EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b TIME OF INJURY P.M. HOUR A.M. MONTH DAY YEAR 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)				
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f LOCATION STREET		CITY OR TOWN	COUNTY	STATE
22a. I certify that I took charge of the remains described above, held an <u>Autopsy</u> <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>								
ACTUAL SIGNATURE <u>DR. GREGORY R. KAUFFMAN</u>								
TITLE (SPECIFY) M.D. Assistant MEDICAL EXAMINER								
DATE SIGNED 4/27/86								
EXAMINER'S NAME (TYPE OR PRINT)		Gregory R. Kauffman, M.D.		ADDRESS		111 Penn St.		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE 5-3-86		23c. NAME OF CEMETERY OR CREMATORIAL Mt. Zion Bapt. Church		23d. LOCATION CITY OR TOWN Roxboro		
24. FUNERAL DIRECTOR NAME Vann & Williams		ADDRESS 4804 Ga. N. W. Wash., D. C.		25a. DATE REC'D. BY REGISTRAR APR 29 1986		25b. REGISTRAR'S SIGNATURE Suzanne Davidson - Janice		

AMERICAN
MUSEUM
OF NATURAL
HISTORY



REG'D. U.S. PATENT OFFICE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-trunk permit. Then please remove carbon paper. Pages 1 and 2 should be mailed within 72 hours after death. IMPORTANT: If Item 21a is marked as "Yes", show every injury, or other traumatic event, the medical examiner will be notified.

00-04495

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1 2 4 1 4

1. DECEASED NAME ANNIE			FIRST	MIDDLE	LAST	20. DATE OF DEATH	MONTH	DAY	YEAR	21. HOUR
3. SEX	4. RACE	5. DATE OF BIRTH				6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR	8:25 pm		
F	Black	MONTH 7	DAY 29	YEAR 1895	90	MONTHS	DAYS	HOURS	MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8	MARRIED <input type="checkbox"/>	NEVER MARRIED <input type="checkbox"/>	WIDOWED <input checked="" type="checkbox"/>	DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH P. T			
10. CITY OR TOWN OF DEATH Adelphi	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Presidential Woods						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)	13b. STATE M.D.	13c. COUNTY P. G.	13d. CITY OR TOWN Temple Hill	13e. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13f. STREET ADDRESS / ZIP CODE 3506 Summit Drive, MD 20748				
14. FATHER'S NAME Charles	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME Rhoda	FIRST	MIDDLE	LAST	16. ADDRESS Temple Hills, Md.			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No	16b. SOCIAL SECURITY NO. 213-56-4747	17. INFORMANT Edward Braxton, son,	18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia.			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost			DUE TO, OR AS A CONSEQUENCE OF Probable Lung Carcinoma							
			(b) (not Biopsy-proven)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I Organic Brain Syndrome, Congestive Heart Failure, Hypertension										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21d. INJURY OCCURRED WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/> AT HOME <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET		CITY OR TOWN	COUNTY	STATE	
22a. I certify that (this hospital) attended the deceased from 3124 1986 , to 615 1985 , that (we) last saw the deceased on 3124 1986 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (We) (I) did not view the body after death.										
22b. SIGNATURE Stuart Turkenitz M.D. DEGREE M.D.										
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Stuart Turkenitz, M.D.		22e. ADDRESS 7500 Greenway Center Dr. Greenbelt, Md. 20770			22f. DATE SIGNED 4/17/86					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Apr 22, 1986		23c. NAME OF CEMETERY OR CREMATORIAL Ft. Lincoln Cemetery		23d. LOCATION CITY OR TOWN Brentwood,		STATE Maryland		
24. FUNERAL DIRECTOR NAME Stewart Funeral Home		ADDRESS 4001 Benning Road, N.E.		DATE REC'D. BY REGISTRAR APR 23 1986		25. REGISTRAR'S SIGNATURE J. Steward, Jr.				

28140-00



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, file it in the funeral director's office as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be detached for use as the burial/transit permit. If item 21 is marked or if item 18 shows any injury, or other traumatic event, the medical examiner should be notified at once.

IMPORTANT: If item 21 is marked or if item 18 shows any injury, or other traumatic event, the medical examiner should be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 6 1 2 4 1 5	REG. NO.		
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR	
Adelaide Louise Wooldridge						April 2, 1986						8:20AM	
3. SEX			4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS.	
Female			White		April 5 1884		101			MONTHS	DAYS	HOURS	MIN.
7a. BIRTHPLACE COUNTRY			7b. CITIZEN OF WHAT COUNTRY?		8		9			9 BALTIMORE CITY OR COUNTY OF DEATH			
Maryland			USA		MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		Prince George						
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION IF NO SUCH EXIST, ADDRESS		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY						
Adelphi			10312 Tulsa Drive		Homemaker								
13a. STATE Md.										13b. COUNTY PG		13c. CITY OR TOWN Adelphi	
13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>										13e. STREET ADDRESS & ZIP CODE 10312 Tulsa Drive 20783			
14. FATHER'S NAME FIRST			MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST			MIDDLE	LAST				
Frederick			C.	Flester	Laura			Adelaide	Luber				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS				
None			214 74 3258			Patricia Airey (Granddaughter)			Same as 13e				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Two weeks			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Arteriosclerotic Coronary Artery Disease</i>										10 yr			
DUE TO, OR AS A CONSEQUENCE OF (c)													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a <i>Terminal Pneumonia</i>													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?				
						YES <input type="checkbox"/> NO <input type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN	COUNTY	STATE		
22a. I certify that (I) (this hospital) attended the deceased from saw the deceased alive on 19 85 July 19 86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I/we) (did) (did not) view the body after death.										19 86 to 19 86, that (I/we) last			
22b. SIGNATURE <i>W.M. Wimsatt</i>			DEGREE			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 4-2-86				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. William M. Wimsatt			22e. ADDRESS 8150 Lakecrest Dr. Greenbelt, Md.										
23a. BURIAL, CREMATION, REMOVAL SPECIFY Burial			23b. DATE 11800 New Hamp.Ave.			23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Hines/Rinaldi Silver Spring, Md. 20904			23d. LOCATION CITY OR TOWN Washington, D.C.				
24. FUNERAL DIRECTOR NAME Hines/Rinaldi			25a. DATE REC'D. BY REGISTRAR APR 02 1986			25b. REGISTRAR'S SIGNATURE <i>Anderson</i>							

1961 100% well set up

1961 well set ground surface

1961 ground surface

1961 well set 100%

1961 well set 100%
well drained

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 4 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

1 - STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 1 2 4 1 6

1. DECEASED NAME Yeon Su Yi						2a. DATE KNOWN OF DEATH 4/24 1986	MONTH DAY YEAR	2b. HOUR 8:11
3. SEX Female	4. RACE Oriental	5. DATE OF BIRTH MONTH DAY YEAR Oct. 8, 1908	6. AGE (IN YEARS LAST BIRTHDAY) 77 yrs.	7. IF UNDER 1 YR. MONTHS DAYS HOURS MIN. 0 0 0 0	8. IF UNDER 24 HRS. MONTHS DAYS HOURS MIN. 0 0 0 0	2c. DATE PRONONCED DEAD 4/24 1986	MONTH DAY YEAR	2d. HOUR P.M.
7a. BIRTHPLACE Korea		7b. CITIZEN OF WHAT COUNTRY? Korea		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED		9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's County		
10. CITY OR TOWN OF DEATH Hyattsville		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 7953 Riggs Road, #6				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		
13a. STATE Maryland		13b. COUNTY Prince George's		13c. CITY OR TOWN Hyattsville		13d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input type="checkbox"/> NO	13e. STREET ADDRESS 7953 Riggs Road, #6	12b. KIND OF BUSINESS OR INDUSTRY 20783
14. FATHER'S NAME FIRST Kwang		MIDDLE Sun		LAST Lee		15. MOTHER'S MAIDEN NAME FIRST Sue Choi		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES, NO, OR UNKNOWN No		16b. SOCIAL SECURITY NO. 213-94-3510		17. INFORMANT Daughter		ADDRESS 222 Springloch Rd. Silver Spring, Md. 20904		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)). PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute myocardial disease DUE TO, OR AS A CONSEQUENCE OF { Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) malnutrition. DUE TO, OR AS A CONSEQUENCE OF (c)								
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH								
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). None								
19a. DATE OF OPERATION None		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20 AUTOPSY? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) None				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN	COUNTY	STATE
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>								
TITLE (SPECIFY) Deputy MEDICAL EXAMINER 1919 Seminary Road EXAMINER'S NAME (TYPE OR PRINT) John S. Rogers, M.D. ADDRESS Silver Spring, Montgomery County, Md.								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Apr. 26, 1986		23c. NAME OF CEMETERY OR CREMATORIAL George Washington		23d. LOCATION CITY OR TOWN Adelphi		
24. FUNERAL DIRECTOR NAME Francis J. Collins, Jr.		25a. DATE REC'D. BY REGISTRAR MAY 1 1986		25b. REGISTRAR'S SIGNATURE Julieta Davidson-Rendell				
500 University Blvd. W. Silver Spring, Md.								

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FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 REC NO.

1 2 4 1 1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is checked or Item 16 shows any injury, or other traumatic event, the medical examiner must be notified.

1. DECEASED NAME (TYPE OR PRINT) FANNIE WEST YOUNG			2a. DATE OF DEATH MONTH DAY YEAR 4 22 86			2b. HOUR 12:50AM	
3. SEX Female		4 RACE Black		5. DATE OF BIRTH MONTH DAY YEAR September 3, 1902		6 AGE (IN YEARS LAST BIRTHDAY) YRS 83	
7a. BIRTHPLACE COUNTRY Virginia		7b. CITIZEN OF WHAT COUNTRY? United States		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGE COUNTY MD.	
10 CITY OR TOWN OF DEATH CHEVERLY		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION PRINCE GEORGE GENERAL HOSPITAL		12a. USUAL OCCUPATION Retired/Practical Nurse		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Maryland		13b. COUNTY Prince Georges		13c. CITY OR TOWN Landover		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST unknown		MIDDLE		15. MOTHER'S MAIDEN NAME FIRST Eliza		MIDDLE LAST	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 577-26-2037		17. INFORMANT 7603 Mountain View Way (20785)		ADDRESS Joan E. Carter (granddaughter) Landover, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>MASSIVE LEFT CEREBROVASCULAR ACCIDENT</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		DUE TO, OR AS A CONSEQUENCE OF (b) <u>SEVERE ELECTROLYTE AND ACID BASE DISTURBANCE</u>					
		DUE TO, OR AS A CONSEQUENCE OF (c) <u>ADVANCED GENERALIZED AND PERIPHERAL ARTERIAL INSUFFICIENCY</u>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) COMPLICATIONS OF MULTIPLE AMPUTATIONS AND SEPTICEMIA							
19a. DATE OF OPERATION 02-13-86		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERTAKEN OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN	
22a. I certify that (I) (this hospital) attended the deceased from <u>01-14</u> , 19 <u>86</u> , to <u>04-21</u> , 19 <u>86</u> , that (I) (we) lost saw the deceased alive on <u>04-21</u> , 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.		22b. DEGREE <i>Anne Zevallos, M.D.</i>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF <input type="checkbox"/> PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 04-22-86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) ANNE ZEVALLOS M.D.		22e. ADDRESS 222 LASTNER LN GREENBELT MD 20770					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 04/26/86		23c. NAME OF CEMETERY OR CREMATORIAL Harmony Memorial Park		23d. LOCATION CITY OR TOWN Landover, P.G.C., Maryland	
24. FUNERAL DIRECTOR Latney's Funeral Home, Wash. DC 20011		ADDRESS Latney's Home 3831 Maude		25a. DATE REC'D. BY REGISTRAR MAY 2 1986		25b. REGISTRAR'S SIGNATURE <i>J. L. Latney</i>	

00-04662

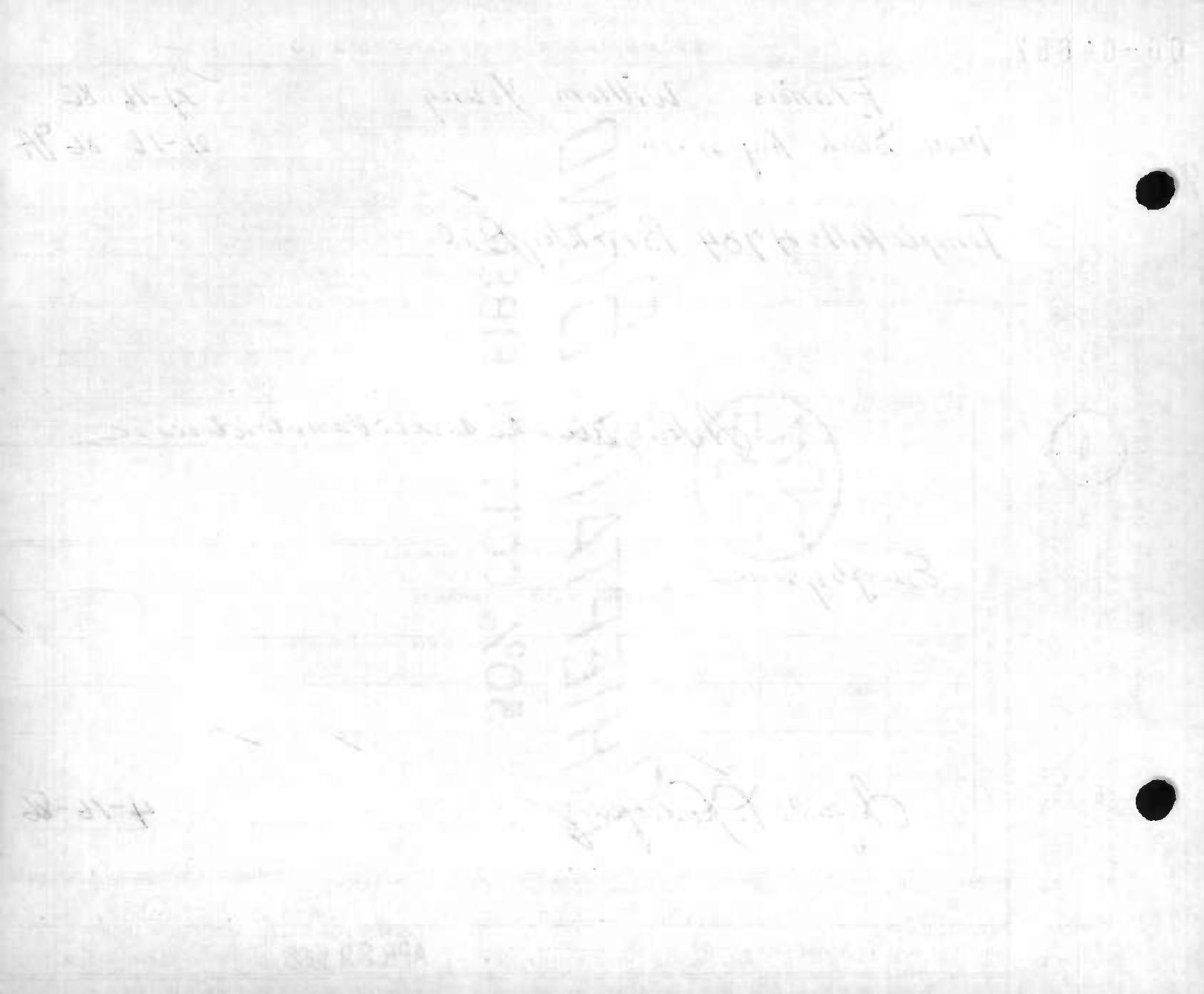
STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 12418

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE WRITING THE WORD "PENDING" IN PENCIL IN ITEM 10. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR.
TO FUNERAL DIRECTOR: PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER AS A BURIAL TRANSIT PERM. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

1-
FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)		FIRST <i>Francis</i>	MIDDLE <i>William</i>	LAST <i>Young</i>	2a. DATE KNOWN OF ESTI- MATED	MONTH <input checked="" type="checkbox"/> 5	DAY <input type="checkbox"/> 16	YEAR <input type="checkbox"/> 86	2b. HOUR 24 HOUR <input type="checkbox"/> M
3. SEX <input checked="" type="checkbox"/> Male		S DATE OF BIRTH MONTH DAY YEAR <i>Aug 21 1907</i>	6 AGE (IN YEARS LAST BIRTHDAY) 78 YRS.	7 IF UNDER 1 YR. MONTHS <input type="checkbox"/> 0	8 IF UNDER 24 HRS. DAYS <input type="checkbox"/> 0	HOURS <input type="checkbox"/> 0	MIN. <input type="checkbox"/> 0		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED		9 DATE PRONOUNCED DEAD <i>4-16-86</i>		9 BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGES MD.	
WASHINGTON, D.C.		UNITED STATES						PRINCE GEORGES PRIVATE <i>20748</i>	
10. PLACE OR TOWN OF DEATH <i>Temple Hills 4704 Brinkley Road</i>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE MARYLAND		13b. COUNTY PRINCE GEORGES	13c. CITY OR TOWN TEMPLE HILLS	13d. INSIDE CITY LIMITS? <input type="checkbox"/> NO X		13e. STREET ADDRESS 4704 BRINKLEY ROAD			
14. FATHER'S NAME FRANK		MIDDLE <input type="checkbox"/> N/A	LAST YOUNG	15. MOTHER'S MAIDEN NAME ELLA		MIDDLE <input type="checkbox"/> N/A	LAST BERRY		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 214-05-2684		17. INFORMANT Rodney L. Young-Rd. Temple Hills, Md.		ADDRESS 4704 Brinkley			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE <i>Arteriosclerotic cardiovascular disease</i>		DUE TO, OR AS A CONSEQUENCE OF <i>(b) Hypertension</i>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause lost.									
(c)									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <i>Emphysema</i>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY?	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY	STATE
22. I certify that I took charge of the remains described above, held on <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE <i>Augusto P. Rodriguez</i>		TITLE (SPECIFY) M.D.		MEDICAL EXAMINER					
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS 5009 Rayburn Ct., Temple Hills, Md.							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE APRIL 19, 86		23c. NAME OF CEMETERY OR CREMATORIAL Mt. Hope Church		23d. LOCATION CITY OR TOWN Ironside		COUNTY Charles	STATE Md.
24. FUNERAL DIRECTOR NAME THORNTON'S FUNERAL HOME		ADDRESS POMONKEY, Md.		25a. DATE REC'D. BY REGISTRAR APR 22 1986		25b. REGISTRAR'S SIGNATURE <i>Julia Davidson-Pendred</i>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be referred by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial permit. Then please remove carbon copies. Page 1 and 2 should be mailed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified or come.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8612419						
												REG. NO.						
1 - STATE REGISTRAR	1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH MONTH DAY YEAR				2b. HOUR							
	ROBERT EDWARD YOWELL						APR 23 1986				0240a M							
3. SEX		4 RACE		5 DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR MONTHS DAYS								
MALE		CAUCASIAN		4 10 36			50			IF UNDER 24 HRS HOURS MIN.								
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8 DATE MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH			10 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			11. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
New York		USA					Prince George's Co.			Andrews AFB		Malcolm Grow Hospital		Inspector		Public Works		
13a. STATE MD		13b. COUNTY St. Mary's		13c. CITY OR TOWN Mechanicsville			13d. INSIDE CITY LIMITS? NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE Route 4, Box 87 20659								
14. FATHER'S NAME FIRST Russell		MIDDLE B.		LAST Yowell			15. MOTHER'S MAIDEN NAME FIRST Lois			MIDDLE B.		LAST Rivenburg						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT Spouse			18. CAUSE OF DEATH (ENTER ONLY ONE CAUSE PER LINE) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE <i>Korea</i>			ADDRESS Walda F. Yowell			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
Yes		091-28-1558					CARDIOPULMONARY ARREST <i>Cardiopulmonary arrest</i>											
							DUE TO, OR AS A CONSEQUENCE OF <i>METASTATIC POOR DIFFERENTIATED ADENOCARCINOMA</i> <i>Metastatic poorly differentiated Adenocarcinoma</i>											
							OF THE LUNG											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a																		
19a. MEDICAL CERTIFICATION DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?										
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART 1 OR PART 2)			YES <input type="checkbox"/> NO <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/>										
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY		STATE						
22a. I certify that (I) (this hospital) attended the deceased from <u>0220 23 April 1986</u> to <u>0222 23 April 1986</u> , that (I) (we) last saw the deceased alive on <u>23 April 1986</u> , and that in <u>my</u> (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.																		
22b. SIGNATURE <i>Michael W. Costello M.D.</i>		22c. DEGREE M.D.			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> MEDICAL STAFF PHYSICIAN <input type="checkbox"/>			22d. DATE SIGNED 23 Apr 86										
22e. PHYSICIAN MICHAEL W. COSTELLO MD <i>Michael W. Costello M.D.</i>		22f. ADDRESS Andrews Air Force Base, MD																
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 4/25/86		23c. NAME OF CEMETERY OR CREMATORIAL Md. Vet. Cemetery			23d. LOCATION CITY OR TOWN Cheltenham			23e. COUNTY		STATE Pr. Geo., MD						
24. FUNERAL DIRECTOR NAME Huntt Funeral Home, Waldorf, MD		ADDRESS			25a. DATE OF DEATH APR 23 1986			25b. DATE OF DEATH REGISTRATION APR 24 1986			REGISTRAR'S SIGNATURE							

00-04964

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NEEDED, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 8. GIVE PAGES 1, 2, AND 3 TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 4 FOR FUTURE USE. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 21201 BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO. 1 2 4 2 0						
1- STATE REGISTRAR																		
1. DECEASED NAME (TYPE OR PRINT)			FIRST			MIDDLE			LAST			2a. DATE KNOWN OF ESTI- DEATH MATED			2b. HOUR			
Philip			Elmer			Ziegler			Ziegler			<input checked="" type="checkbox"/> 4-25-86			M 14 25 86			
3. SEX			4. RACE			5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YR.		IF UNDER 24 HRS.		2c. DATE PRONOUNCED DEAD		
Male			Caucasian			12-22-14			71 yrs.			MONTH		DAYS		4-25-86		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8			9			BALTIMORE CITY OR COUNTY OF DEATH						
Missouri			United States			MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>			WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			Prince George						
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT LISTED ON LINE 7a, PRINT NAME)									12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY			
Clinton			Southern Maryland Hospital									Money Clerk			Railway Exp			
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS						
Md.			Prince George			Friendly						10209 Griff Drive						
14. FATHER'S NAME			FIRST			MIDDLE			LAST			15. MOTHER'S MAIDEN NAME						
Elmer			Ambrose			Ziegler						Lenora Gertrude Aplin						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yes			16b. SOCIAL SECURITY NO. 5-44-12-45			16c. INFORMANT 577-12-0531			17. ADDRESS Grace M. Ziegler			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Knife wounds of the neck & pulmonary insufficiency</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
19a. DATE OF OPERATION 3-17-86			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? <i>neck wounds</i>			20 AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>												
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR <input checked="" type="checkbox"/> AM MONTH DAY YEAR P.M. 3-17 1986			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) <i>self inflicted</i>												
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) Home			21f. LOCATION STREET 10209 Griff Drive, Ft. Washington, Md. 20744			CITY OR TOWN COUNTY STATE									
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/>			and in my opinion												
ACTUAL SIGNATURE <i>Augusto P. Rodriguez</i>			TITLE (SPECIFY) M.D. Deputy			MEDICAL EXAMINER			DATE SIGNED 4-25-86									
EXAMINER'S NAME (TYPE OR PRINT)			Augusto P. Rodriguez, M.D.			ADDRESS 5009 Rayburn Ct., Temple Hills, Md.												
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE Burial 4-28-86			23c. NAME OF CEMETERY OR CREMATORIAL Trinity Mem. Gardens			23d. LOCATION CITY OR TOWN Waldford			COUNTY Charles						
24. FUNERAL DIRECTOR NAME Huntt Funeral Home			ADDRESS Box 156 Waldford, Md. 20601			25a. DATE REC'D. BY REGISTRAR APR 28 1986			25b. REGISTRAR'S SIGNATURE <i>Julia B. Danner</i>									

40010-00

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